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WE DIED AND WERE REBORN: AN ANTHROPOLOGICAL STUDY OF HEALTH-SEEKING STRATEGIES FOR MENTAL AND EMOTIONAL DISTRESS IN POST-WAR EASTERN SRI LANKA

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DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Arts and Sciences at the University of Kentucky

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ABSTRACT OF DISSERTATION

WE DIED AND WERE REBORN: AN ANTHROPOLOGICAL STUDY OF HEALTH-SEEKING STRATEGIES FOR MENTAL AND EMOTIONAL DISTRESS IN POST-WAR EASTERN SRI LANKA

Since the early 2000s, Sri Lanka has made major gains in decentralizing and expanding state-based mental healthcare access and services outside of Colombo. However, little evidence exists related to on-the-ground experiences of Sri Lankans who access these services, the quality and sustainability of services, and the effects services have on individual therapy management of mental and emotional distress. In addition to an extensive historical review of mental health service provision, this dissertation explores strategic health-seeking practices among Tamil-speaking communities in eastern Sri Lanka—an area ravaged by high rates of poverty, 26 years of civil war, and the 2004 tsunami catastrophe. Across 21 months of ethnographic research, I observed psychiatric, traditional, and religious mental healthcare practices and client interactions with both doctors and healers. I also conducted 58 semi-structured interviews with clients, family members, mental health doctors and staff, and traditional healers. I analyze clients' life histories, local pluralistic therapies, as well as socioeconomic changes in post-war eastern Sri Lanka shaping experiences of suffering, treatment practices, and accessibility to resources and knowledge. I document the origin of mental health services in the east, subsequent barriers associated with increased demand for services, organizational changes, and a significant decrease in resources. Such social changes led to a heavy reliance on inexpensive biomedical drugs to alleviate mental illness and emotional distress. Given these shifts, and stigma associated with state-based mental healthcare, clients find strategic ways to associated with psychiatric treatments. This research positions local expressions of distress as tied to South Asian cultural ideas about mental health, and social inequalities linked to changing gender roles, transnational labor, sexual morality, and family economic status. Evidence collected from this research builds on existing contextually-based analyses to inform global health campaigns aimed at improving access to mental healthcare. Research and practice must adopt a more nuanced view of historical features, cultural processes, and socioeconomic changes that present challenges and/or opportunities for doctors and residents seeking out mental healthcare in post-war settings.

KEYWORDS: Health-Seeking Strategies, Anthropology of Medical Pluralism, Global Mental Health, Sri Lanka, Social Suffering

Daniel David Ball_____

___June 25, 2020_____
Date

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I wish to show my sincere gratitude to all the Sri Lankan mental health staff, clients, family members, and other research participants. With kindness and hospitality, these individuals spent countless hours telling me their stories, sometimes describing terrible circumstances living under the conditions of war and poverty. I do not list these people individually in order to protect their privacy. I hope this research sheds light on both challenges and achievements of local therapies that residents use to manage mental and emotional distress in eastern Sri Lanka.

TRANSLITERATION

All Tamil words and expressions are transliterated with an English spelling that closely imitates the Tamil pronunciation without the use of diacritical marks. These words, when first used, are italicized. All Tamil interviews were completed using a research assistant, Nasrudeen Buhary, a psychiatric social worker in eastern Sri Lanka. I solely carried out all English medium interviews with mental health physicians, staff, and key informants.

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Chapter 1: Introduction

This dissertation explores health-seeking strategies for alleviating mental and emotional distress among Tamil-speaking patients (*nooyaalis*)[1] in state-run mental health services in post-war Batticaloa District, eastern Sri Lanka. By "strategies," I refer to agentive, personalized creative acts by both doctors and clients when encountering different therapies, bureaucratic routines within mental healthcare, and political economic pressures. Sri Lanka has seen major changes to its mental healthcare system over the past two decades. Following catastrophic destruction in the wake of the 2004 tsunami, there was greater attention from global health authorities and the Sri Lankan government to decentralize and improve outdated psychiatric practices in state-run mental health services. At that time, services were mostly centralized around one mental hospital, Angoda, near the capital city of Colombo. The massive global humanitarian response to the tsunami spurred opportunities to build mental health facilities and develop specialized training programs for medical officers (MOs), nurses, and other mental health staff. These programs initiated an expansion of mental health services to other districts, particularly Tamil-speaking, war-torn areas of the north and east.

Changes in Sri Lanka's mental health services were part of larger discourses focused on lessening "treatment gaps" in mental healthcare in low- and middle-income countries, now commonly referred to as global mental health (GMH) (Kohrt and Mendenhall 2015; Patel et al. 2014; WHO 2001, 2008). After the tsunami, there were efforts by Sri Lankan psychiatrists and World Health Organization (WHO) authorities to go beyond psychiatric, biomedical, or drug treatment approaches. These so called "community-based" approaches emphasized clients' psychosocial needs and extend mental health services beyond clinics and wards (Campbell and Burgess 2012; Fernando and Weerackody 2009; WHO 2013). Given these transformations, recent

[1] Throughout the dissertation, I use "client" and "patient" interchangeably. Both terms were commonly used among local mental health staff. My usage of "patient" is not meant to imply passiveness or to remove agency on the part of clients interviewed or observed for this study.

narratives about Sri Lanka's mental health services largely document successful examples of "building back better" (see WHO 2013), with an emphasis on finding opportunities to develop mental healthcare in the aftermath of psychosocially disruptive crises such as war or disaster.

Based on 21 months of ethnographic fieldwork in Batticaloa District, I found recent developments in mental health services were complicated by changing sociopolitical landscapes and different cultural understandings of mental and emotional distress among local pluralistic therapies (Fernando amd Weerackody 2009). My study of state-run mental health services and health-seeking strategies in Batticaloa District shows nuanced narratives in which consultant psychiatrists, medical officers, and clients develop personalized strategies to care for and alleviate distress in shifting post-war political economic conditions with limited material and human resources.

Though treatment gaps have narrowed regarding access to psychopharmaceuticals and doctors trained in psychiatry, in Sri Lanka, mental health services have been hampered by a history of staff shortages, fluctuations of state resources, overstretched facilities, and overall unfavorable ideas about state-based psychiatric services and people living with mental illness. I argue such historical, cultural, and political economic shifts continue to influence access to state-based mental health services and affect how Sri Lankans treat, heal, and manage their mental and emotional distress. In Batticaloa District, during the civil war and after the 2004 tsunami, I found there were major developments made by the first consultant psychiatrist, Dr. Ramesh[2]. Since Dr. Ramesh's departure, there have been socioeconomic changes in the district, and minimal amounts of material and human resources dedicated to mental health services. As such, doctor-patient interactions and mental healthcare practice became more bureaucratic and medicalized, with a heavy focus on treating symptoms and disorders through psychopharmaceuticals and maintaining drug compliance.

[2] All names of informants and places in Batticaloa District are pseudonyms unless otherwise indicated.

As Batticaloa District transitioned from a complex humanitarian emergency setting to a post-war context, NGO and state resources were redirected (e.g., the district health authority reallocated mental health unit vehicles to other health campaigns like malaria prevention). Considering a general increase in client population since 2000, mental health staff face considerable constraints carrying out what Dr. Ramesh called "friendly services," his personalized and adapted set of practices and ideas that were the foundation of mental healthcare in Batticaloa District.

Under mounting pressures of large patient loads, former community-based, ad hoc, outreach programs became swallowed up in bureaucratic procedures of drug distribution and management. Mental health physicians and staff have little opportunities to engage in community-based interventions, nor to spend significant amounts of time in clinics with patients addressing their psychosocial problems. Therefore, there are few resources for the development of outpatient services and programs to address psychosocial determinants of distress beyond drug treatment and compliance. Limited opportunities exist for talk and/or group therapy regarding clients' distress within the current services. My ethnographic research reveals the routes clients take to alleviate, adapt, or cope with the anxieties, vulnerabilities, sadness, tension, and/or distress tied to changing sociocultural and political economic landscapes.

When I first visited Sri Lanka in the summer of 2013, I joined Dr. Pradeep, a local medical officer trained in psychiatry who agreed to let me observe his community outreach activities. We went to a rural village named Cinnanari in Batticaloa District. On our way to Cinnanari, Dr. Pradeep and I passed numerous villages scattered along the road. Some littered with bottles, fireworks, and other trash—remnants of temple (*kovil*) festival (*thiruvilaa*) activities from the previous evening. During the hot season (*cutu kaaram*), festivals are held on dry and arid landscapes throughout the east. Annual week-long celebrations occur in temples, neighborhoods, and villages (*kiraamam*) of a variety of sizes. It is common to see extravagant decorations and colorful lights lining temple grounds and roads leading to its entrance. During

these festivals, temples bustle day and night with venders, pilgrims, locals, and a loud mixture of sounds such as Tamil music, drums, and nadaswaram horns.

On this day, I observed Dr. Pradeep's outreach program that taught techniques to manage stress, discussed addiction and substance abuse, and raised awareness about mental illness in rural, war-affected communities. With the demands of clinic and ward work at the hospital, Dr. Pradeep was rarely able to conduct these outreach and community-based programs. I watched him gather adolescents and adults under a shaded structure to present psychosocial support posters and other materials that were labeled at the bottom with World Vision and other funders. Earlier in the day, we visited an income generation program funded by the European Union that grew cashew trees and harvested the nuts, one of many international aid projects throughout the district implemented during the three-decade civil war and the 2004 tsunami response.

Traveling to Batticaloa region, it is hard not to notice networks of lagoons that divide land masses, rising and falling with the ocean tide. To reach Cinnanari, we needed to cross a section of the lagoon. We boarded a rickety small-engine platform boat that was loaded with people, motorcycles, a truck, and livestock. We were all waiting to cross to the other side. A bridge built by the Japanese government in 2016 now connects the two land masses together, increasing connectivity to larger towns and resources. Prior to visiting, I read and heard stories about how rural towns in the north and east suffered the worst atrocities during the civil conflict (*yuttam*) between Tamil militants—most notably, the Liberation Tigers of Tamil Eelam (LTTE), and the Sri Lankan military forces (Daniel 1996; Lawrence 1997a, 1998, 2000; Somasundaram 2007; Trawick 2007). With the regular shifting of government and LTTE control in rural areas, people living in these outlying villages faced protracted conscriptions and ransoms from LTTE, in addition to government military arrests and abductions.

Dr. Pradeep facilitated psychological support groups for men in Cinnanari. As men gathered, I observed Dr. Pradeep and the group members talk about loans and financial problems, domestic conflicts, stress relief, traumatic memories and war-related injuries, as well as other

social and personal problems. When the group session ended, Dr. Pradeep smiled at me and said, "Do you have a question? Feel free, ask." Feeling a little on the spot and looking at the tired, sun-roasted faces, I responded, "I'm okay. Just do what you would normally do." In a causal manner, Dr. Pradeep said, "You want to ask about the war?" Not wanting to bring up such a sensitive topic in that moment, I scrambled to defuse this line of questioning, "No, no, it's fine." Dr. Pradeep was impacted both professionally and personally by the war and was open about the lasting impact the conflict had on his family. Growing up in the north, he lost both his brother and sister to civil war-related violence. These deaths, he claims, continued to haunt and strain his mother and have contributed to her poor health and on-set of dementia in recent years.

Dr. Pradeep himself asked if the group had anything to say about the war. His question was met with a diversity of facial expressions and a momentary silence. Clearly each group member had unique experiences, yet they shared an understanding of being affected by the destruction and death brought by living on or near battlefields. Then, a couple of small discussions started. Eventually, one man spoke up. He simply said, "We died, and were reborn." His statement resonated with me over the years as I observed transformations of Sri Lankans, places, and institutions moving from war to post-war social conditions. I interpret the "we"—Cinnanari community members, Dr. Pradeep, and possibly Tamils—as a shared experience of losing family members, having assets/property destroyed or extorted, and other forms of suffering—i.e., a "collective trauma" (Abramowitz 2005; Robben and Suarez-Orozco 2000; D. Somasundaram 1998, 2010, 2014), or as the ecological features of trauma and violence that go beyond individuals and affect families and communities. I later learned the man's brother had been a "black tiger" in the LTTE, a special unit of dedicated soldiers who carried out suicide bomb attacks. I did not have a discussion with him about what he said and never saw him again. When I asked Dr. Pradeep later about the comment, he said, "Powerful stuff, huh?" Such interactions, discussions, and conversations are crucial to understanding both personal

experiences and shared cultural understandings of therapy management for mental and emotional distress in a post-war context.

Ethnographic research in Sri Lanka shows how individuals and families living in war-torn areas use local rituals and forms of healing to make symbolic transformations of their suffering and terrible experiences so they can manage, adapt, and cope with war conditions (Derges 2013; Lawrence 1997a, 1998, 2000, 2010; Thurnheer 2009, 2014; Walker 2013). Though Sri Lankans' experiences may be linked—whether by ethnicity, regional background, rurality, and so on, it is important to illuminate individual variabilities of suffering, and ways people express and transform themselves through shared cultural practices and knowledge (e.g., religious, education, medical, etc.). Sri Lankan anthropologist Gananath Obeyesekere (1981, 1985, 1990) refers to these creative or meaning-making activities as "the work of culture."

While carrying out ethnographic research in Batticaloa District for this dissertation, I began to observe such meaning-making acts by doctors, staff, clients, and family members within mental health units, doctor-patient interactions, and individual therapy management. A metaphor of death and rebirth highlights sociocultural transformations in both individuals and institutions, adjusting to new roles and statuses, and encountering local morals and ideas regarding mental illness. To highlight individual and collective experiences of mental health concerns, I investigate local idioms of distress (Nichter 1981) and healthcare decisions as pragmatic creative acts and expressions of social suffering, people's everyday stressors or miseries that are tied to fragmenting social and economic changes (Bourdieu, Accardo and Emanuel 1999; Kleinman, Das and Lock 1997). Health-seeking narratives of clients in this study illuminate alterations in their statuses, roles, and overall notions of self as they navigate traditional and/or religious healing and state-run medical services in order to manage mental and emotional aliments.

With greater movement of people and goods in Batticaloa District's post-war context, informants for this study suggested the war-related collective suffering that used to tie locals together has transitioned to a more fragmented suffering due to increased individualism, micro-

crediting, consumerism, and other recent socioeconomic trends. With such socioeconomic changes and disruptions happening at different ecological levels (institutional, interpersonal, and individual), ethnographic research provides a layered viewpoint of local actions and language that shape the experiences of both doctors and clients. For this study, according to the WHO's International Statistical Classification of Diseases—tenth edition (ICD-10)[3] (WHO 2004), I focused on outpatients accessing services who had been diagnosed with neurotic, stress-related, and somatoform disorders (F40-48) (i.e., not major mood and delusional disorders). Clients' life and health-seeking histories illuminate their negotiations with local sociocultural boundaries of what is considered crazy/madness (*paittiyam*) or mental illness (*mana nooy*). In particular, I investigate ways clients interact with and access both professionalized and informal forms of healthcare.

Global Mental Health

With rapid changes to technologies and the intensification of market-based economies globally since 1980s, international health authorities shifted towards transnational public health planning and away from strategies focused on baseline health indicators (e.g., under five morality rate) and developing nation-state healthcare systems (Brown, Cueto and Fee 2006; Bunyavanich and Walkup 2001; Foster 2010; Nichter and Kendall 1991). Such "global health" trends place great emphasis on biomedical sciences, biosecurity, and humanitarian and philanthropic values in solving public health problems across national or political boundaries (Collier and Lakoff 2013; Lakoff 2010; Janes and Corbett 2009). Thus, global health interventions have been characterized as market-driven, vertical, disease-specific, and rooted in public-private partnerships (NGOs, privatized areas of healthcare) (Keshavjee 2014; Lee, Buse and Fustukian 2002). According to Cohen, Patel and Minas (2014), the origins of global mental health can be traced to the publication of the World Development Report 1993 and its study of the Global Burden of Disease

[3] Doctors in mental health units diagnosed and treated according to guidelines in the ICD.

(GBD). Previous international health studies emphasized measures of communicable diseases (e.g., malaria, HIV) and mortality figures, while the GBD study examined non-communicable diseases and chronic health issues worldwide (World Bank 1993). Utilizing these findings and anthropological scholarship, Desjarlais et al. (1995) wrote the influential book *World Mental Health,* which widely examines mental health problems in low-income countries such as violence, substance abuse, displacement, and age-related and gendered issues. The actual term "global mental health" (GMH) was first used by the U.S. Surgeon General, David Satcher, following the publication of the 2001 World Health Report (Satcher 2001; White et al. 2017; WHO 2001). This report gave an extensive overview of mental and behavioral disorders in low- and middle-income countries, and of public health strategies to address deficiencies in mental health systems. Movements for GMH began to take hold after a group of mental health experts published a range of articles in The Lancet in 2007 and 2011. These articles illuminate serious resource gaps in mental healthcare and psychosocial support in the global South and brought attention to the idea of "no health without mental health" to global health campaigns and missions (Prince et al. 2007).

Critical perspectives from anthropologists and psychiatrists of GMH movements have echoed earlier critiques of cross-cultural applicability of westernized and standardized psychiatric techniques and the medicalization of distress and social problems in 1960s, 1970s, and 1980s (Foucault 1965, 1975; Illich 1976; Ingleby 1980; Kleinman 1977, 1988; Szasz 1961). Given the prominence of biomedical sciences and technologies among global health authorities like the WHO, ethnographic research illuminates on-the-ground deficiencies and complexities when macro-level standardized or "one size fits all" biomedically-based interventions are implemented at the local level and in resource-low settings (Biehl and Petryna 2013; Castro and Singer 2004; Kim, et al. 2000; Kohrt and Mendenhall 2015; Maternowska 2006; Whiteford and Manderson 2000). Critical anthropological viewpoints on global health and humanitarian relief programs, particularly in contexts of protracted violence, war, and/or disaster, demonstrate how bureaucratic

and biomedical interventions may disrupt local forms of social support, limit access to other forms of healthcare, disturb preventative care and treatment services, and condense everyday social experiences and cultural understandings of suffering to quantitative, biological, and epidemiological measurements (Biehl 2005; Bornstein and Redfield 2011; Farmer 1992; S. Fernando 2014; Kleinman, Das and Lock 1997; Robben and Suarez-Orozco 2000; Sargent and Larchanché 2011; Rylko-Bauer, Whiteford and Farmer 2009).

Such biomedical standardization in global health aims for uniformity across political boundaries and sociocultural institutions in order to regulate and implement professionalized knowledge and technologies through statistics, paperwork, policies, and practice (Closser 2010; Hyde 2007; Koch 2013; Nguyen 2010; Whitmarsh 2008; Zigon 2010). Anthropologists show how biomedical interventions tend to focus on the individual biology, symptoms, drug treatments, and specific illnesses or parts of the body, which can divert attention away from social determinants of people's illness or distress (Lock and Nguyen 2010; Mol 2002; Rose 2007; Susser 2009). In resources-low settings, standardized biomedical procedures can take on different forms when cross-culturally implemented by local caregivers and institutions (Berg and Mol 1998; Livingston 2012; Wendland 2010). Ethnography illuminates how abstract medicalized knowledge becomes meaningful in a specific context of use. Anthropological studies show how biomedicalization can be a highly variable process informed by shifting human and material resources and sociocultural morals tied to local and global political economic trends. Such variability affects the quality of services, access to services, systems of classifications, and treatments in mental healthcare and other services.

Anthropologists and psychiatrists have shown how the diagnosis and treatment of Posttraumatic Stress Disorder (PTSD) may limit and standardize cultural meanings of suffering and the self across diverse social groups, idioms, and experiences (Bracken and Petty 1998; Breslau 2000; Jenkins 1991; Kienzler 2008; Pedersen 2002; Young 1997; Water 2010). Argenti-Pillen's (2003) ethnographic work analyzes gender and the social fabric of an impoverished,

mostly Sinhala, rural community in southern Sri Lanka. Many of the women she interviewed and observed were linked to soldiers fighting in Sri Lanka's civil war and were terrorized by violence from the JVP insurrection in the late 1980s. She illuminates how a PTSD diagnostic criterion of psychological avoidance of trauma-related thoughts and external reminders run counter to local discursive strategies that contain local social disruption. She demonstrates that NGO therapies for PTSD are potentially dangerous to local social dynamics because women are encouraged to fashion themselves towards behaviors of fearlessness, which locals typically associate with possessive states and violent intentions spurred by wild spirits (known as *yakas*).

Moreover, Sri Lankan psychiatrist Somasundaram's (1998, 2010, 2014) qualitative research on Sri Lankan Tamil communities living under war conditions in the Vanni region and the north demonstrates how an individualistic biomedical diagnosis of PTSD does not adequately incorporate or address Tamil clients' social worlds (family and community) and cultural understandings of self and health. In Chapter 2, I discuss in detail historical and sociocultural dimensions of mental and emotional health in Tamil-speaking communities. Such studies in Sri Lanka, and elsewhere, demonstrate how the adoption of biomedical models and standards may minimize (or ignore) contextual factors, negatively affect local habits and needs, and transform meanings of distress through bureaucratic and technological responses, expert knowledge, and healthcare institutions (Abramowitz 2010, 2014). With increased developments and access to psychopharmaceuticals globally since the 2000s, anthropological research shows heavy use of psychopharmaceuticals can exclude or restrict other forms of healing and local cultural ideas regarding mental and emotional distress (Applbaum 2006; Ecks 2013; Jenkins 2010; Lakoff 2005; Petryna and Kleinman 2006).

In places like Batticaloa District, there was a circulation of people and goods due to aid relief from abroad that shaped how mental health services were carried out. Though there were efforts by Sri Lankan psychiatrists and mental health advocates to decentralize and expand mental health services in Sri Lanka prior to the 2004 tsunami, this catastrophic event provided an influx

of international resources and actors that shaped the implementation of mental health and psychosocial programming, especially in the east and north. A lacuna of research exists regarding health-seeking, accessibility, and the long-term effect of GMH programs on state-based mental health systems in post-war conditions. This project explores the recent developments of mental health services in Batticaloa District, and Tamil-speaking clients' experiences and expressions of distress as they navigate such services. Eastern Sri Lanka is a compelling context to investigate GMH programming and expressions of distress, with recent developments in mental health services, and an ethnically diverse population of Tamil-speaking minorities who weathered through three decades of civil war, the 2004 tsunami, influxes of international aid, and high rates of poverty.

In eastern Sri Lanka, therapy management is no simple matter given the stigma surrounding mental and emotional problems, especially when seeking out state-run mental healthcare linked to biomedical, psychiatric interventions. Thus, for this dissertation research, I chose to mostly focus on state-run, formalized, and biomedical mental health services, and how such services influence expressions of distress and patients' health-seeking patterns.

Mental Health Services in Sri Lanka

The South Asian island country of Sri Lanka has a population of 21.8 million and is divided ethnically between Sinhalese (75%), Tamils (15%), Muslims (9%), and other groups (1%) (DCS 2012). Sri Lanka has a 2000-year-old history of practicing different types of medicine, including ayurveda, siddha, unani, and western/allopathic/biomedical (Uragoda 1987). In the modern era, though there are serious resource gaps in the country's healthcare system and public health programs, Sri Lanka has sparkling healthcare statistics when compared to neighboring South Asian countries in low-/middle-income brackets. The country's key health indicators are comparable with countries of higher income brackets: life expectancy is 78.6 years for women and 72 years for men, and the infant mortality rate is 8 per 1,000 live births (MOH 2016).

In 2016, Sri Lanka was declared malaria-free due to strong eradication programs. Such results are largely attributed to an emphasis on social welfare and public health preventive measures rather than simply curative practices. Scholars suggest these health and social policies were spurred from the 1934-37 malaria epidemic that killed 1% of the population, and from universal suffrage movements leading up to Sri Lanka's independence in 1948 (K. T. Silva 2009; Jones 2000). These factors extended healthcare services to more rural areas of the country, entrenched welfarism in national politics, and included the provision of free health care, food subsidies, and free education. In 1949, Banaranaike, the Minister of Health at the time, issued a statement declaring the government's healthcare efforts were in line with the WHO's concept of health as a fundamental right. Such guarantees are still highly valued by Sri Lankans, but people regularly supplement deficiencies in state-based healthcare by accessing private services.

Though healthcare in ayurveda, siddha, unani, and traditional healing existed centuries before colonial rule in Sri Lanka, westernized psychiatry provides the key foundations for state-run mental health services today. Despite Sri Lanka's health statistics being reasonably good, the country has suffered serious shortcomings regarding psychiatry and mental healthcare since British colonialism. State-run mental health services have mostly been centralized around the capital city Colombo; specifically, the mental hospital known as Angoda (now called the National Institute of Mental Health), established in 1926. The WHO's 2011 Mental Health Atlas highlights human and material deficits in Sri Lanka's mental health system per 100,000 people: .005 mental hospitals, 1.36 mental health outpatient facilities, .29 psychiatrists, .75 medical officers trained in psychiatry, .33 social workers, and .09 psychologists (WHO 2011). There has also been a serious lack of state funding. The total budget for mental health in Sri Lanka was $8,473,392 USD in 2008-2009, which represented 1.7% of the total national health budget (Raja, et al. 2010). In the distribution of funding, 76% of the national mental health budget is spent on three major mental hospitals: Angoda, Mulleriyawa, and Hendala. For numerous years, the country has had one of the highest suicide rates in the world (Knipe et al. 2014; Marecek 1998, 2006; Marecek and

Senadheera 2012; Widger 2012). Currently suicide/self-harm ranks as the eighth leading cause of death in the country. Though preventive measures for suicide have been implemented since the 1980s—such as the banning of pesticides and removing poisonous plants, my ethnographic research in mental health units indicate suicide continues to be a major societal problem in eastern Sri Lanka as new technologies (cellphones, Facebook, etc.) and financial services (microcredit loans) bring a range of stressors for residents, particularly in war-torn areas.

Fieldsites and Methodology

I collected data for this ethnographic project between November 2016 and May 2018. I arrived in Sri Lanka in August 2016 and immediately began sessions with my language tutor, Ms. Rajes, who was in her eighties and grew up in Batticaloa District. She had excellent historical knowledge of the district and would sometimes accompany tours of cultural sites for a local tourist agency ran by an expatriate. Given her knowledge and connections to important people and organizations—along with gossip about the latest happenings in the district, she helped me improve my Tamil language competency and gain acquaintances for this project. She also served as treasurer for the Butterfly Peace Garden—an art program for children and adolescents, where kids had a safe place to play, perform/act, and paint/draw (see Lawrence 2003). Unfortunately, while I was there, it closed due to a lack of support/funding and internal staff issues. As Batticaloa moved from a "war" context, NGO funds and international relief has been shifted to other parts of the country, or, resources were channeled to other humanitarian conflicts and disasters happening around the globe.

For most of my stay in Batticaloa District, I rented a house located in a tsunami-affected fishing community. I would frequently see fisherman in the early mornings or late evenings heading out to sea to catch fish to sell in the morning market. From November 2016 until February 2017, I spent much of my time going to key religious sites (churches, temples, mosques), community events (sporting events, holidays), and hospitals. I informally chatted with mental health staff and met with hospital administrators to get approval and fill out required

paperwork in order to conduct observations in state-based wards and clinics in the district. During this period, I was also seeking IRB approval in-country with a local university and my home university, which required permission from medical superintends/directors of hospitals, regional and district health services, as well as the Ministry of Health. Getting permission and approval took considerable time as I learned to navigate these networks of authority. After I received approval from an in-country university and the University of Kentucky in March 2017, I began spending most of my time in mental health wards and clinics.

This ethnographic study employed methods of participant observation and semistructured interviews in three state-run biomedical psychiatric units, referred to as Hospitals A, B, and C, in order to better anonymize clients. I also conducted life history interviews with five patients from these sites. Participant observation enables researchers to learn about political structures and cultural characteristics through exposure to and participation in routine social practices of institutions or other contexts (Bernard 2006; Schensul, Schensul and LeCompte 1999). Participant observation also provides contextual details not always present in informant interviews. Appendix A contains a descriptive table listing specific methodologies as well as informant characteristics.

The first district mental health unit was established at Hospital A in 1999. Hospital A is a larger hospital and houses numerous specialties and wards. The mental health ward space includes numerous staff: the consultant psychiatrist (Dr. Chamil), medical officers with training in psychiatry, occupational therapists, psychiatric social workers (PSWs), nurses, and attendant staff. In 2006, a mental health unit was established at Hospital B, a medium-sized hospital. During data collection, the mental health unit at Hospital B was mostly managed by Dr. Pradeep. In 2016, a mental health unit at Hospital C was established, also a medium-sized hospital. Hospital C's mental health unit was mostly managed by Dr. Rita, a medical officer trained in psychiatry, from Batticaloa District, who has worked in the district for numerous years. I also observed and interviewed indigenous practitioners (ayurveda, siddha, and unani), traditional

healers (*paricari*), and Roman Catholic priests (the largest Christian population in the district). The current research focused on healthcare interactions between patients, family members, and caregivers in each hospital in order to better understand meaning-making acts and sociocultural transformations within the structures, routines, and micro-politics of medical dialogues (Crandon-Malamud 1986, 1991; Good 1994; Kleinman 1980; Stein 1985; Waitzkin 1991). I also observed and recorded (in fieldnotes and audio recordings): social interactions in waiting rooms, physician meetings about patients, and staff meetings. These observations provide documentation of institutional arrangements and on-the-ground accessibility of care in hospital A, B, and C.

It was not always easy to obtain permission and consent to audio record from each and every patient and family member. Given the sometimes chaotic nature and briefness of clinic and ward consultations—the room could be filled with multiple patients, family members, and mental health staff, and, doctor-patient consultations may last only a minute or two. Therefore, I chose to only audio record longer, more controlled, doctor-patient-family consultations. Most doctor-patient dialogues were analyzed through fieldnotes and not transcribed audio recordings.

Data from participant observation offers insight into how new and returning careseekers are diagnosed/labeled and treated for mental and emotional distress at each mental health unit through patient-intake forms, discussions, and other routines. I also observed patients' and caregivers' reactions to, and discussions of, inquiries and problems associated with distress. I also attended to ways socioeconomic problems are addressed in order to comprehend how (or if) medical practices incorporate patients' social determinants of distress. Though I mostly focused on patients' managing of distress and neurotic or minor forms of mental illness, I also observed procedures in mental health services for treating psychosis, delusions, or more severe forms of mental illness. Given stigma, and current lack of community-based outreach programs and home visits, I spent most of my time in state-based clinic and ward spaces. I therefore did not develop strong relationships with patients outside of clinic environments, and instead built relationships with staff members and others connected to mental health services.

All 58 informants (clients, family members, and formal/informal caregivers) for this study were recruited through purposive sampling techniques. With purposive sampling, the researcher decides on what purposes he or she wants informants to serve and recruits accordingly (Bernard 2006). For this study, I gathered perspectives from patients and caregivers that captured differences and inequalities between ethnicity, gender, religion, age, and class within and outside of clinic spaces. Semistructured interviews include organized predetermined questions that can be answered in an open-ended manner, and augmented or expanded to address unanticipated issues (Bernard 2006; Schensul, Schensul and LeCompte 1999). Life history interviews capture greater details about the biographies and backgrounds of five client informants (Denzin 1989; Frank and Langness 1981).

All interviews with patient respondents were carried out in Tamil with assistance from Nasrudeen Buhary, a psychiatric social worker (PSW) who is from eastern Sri Lanka. My status as an unmarried man meant that it was too taboo for me to collect intimate details related to women's sexuality (or other sensitive topics). Such questions would have been inappropriate, yet, this gap represents a limitation of the current study. Future scholarship should aim to better understand gendered issues related to mental and emotional distress, and related health-seeking processes in the east. I carried out all interviews with healthcare workers and key informants in an English medium. Healthcare workers and key informants included: six medical officers (Bachelor of Medicine, Bachelor of Surgery (MBBS)) with either diploma in mental health or psychiatry); two consultant psychiatrists (MD post-graduate training with international residency); three nurses; one psychiatric social worker; one occupational therapist; two ayurveda/unani/siddha doctors; three Catholic priests; two traditional healers (*paricaris*); and a WHO employee (See Appendix A).

I initially had difficulties recruiting patients who were considered to have forms of non-severe mental illness. To do this, I relied on physicians to determine if patients were interested, stable, and did not have problems with psychosis or other more severe forms of mental illness. As

I recruited clients that fit this criterion, I interviewed them in the clinic or at their house, depending on their preference. It was difficult to carry out patient observations outside of the clinic and ward settings due to the highly stigmatized nature of accessing state-run mental health services. Therefore, I shifted my focus to observe power dynamics within the clinic and ward setting, and other mental health-related programs. Tensions and conflicts between different types of healthcare workers are illuminated in my observation and interview data. During fieldwork, I developed a strong rapport that allowed me to better understand differences of opinion in how services should be carried out, and also who lacked influence due to their lower status among healthcare staff.

Data analysis began during data collection and continued after fieldwork. Data analysis for this project takes a "grounded theory" approach, which identifies key symbols and categories from transcribed texts and groups them according to formal theoretical frameworks (Bernard 2006; Strauss and Corbin 1990). This approach enabled me to link categories within textual data in order to build theoretical models, while reevaluating these models amidst ongoing data coding and analysis. The qualitative software, NVivo 12 Pro, enabled coding of multiple types of data to identify themes across texts that were not easily apparent. All transcribed materials were coded for topical themes/patterns linked to idioms of distress; socioeconomic challenges/barriers; medicalized or bureaucratic routines; sociopolitical features of doctor-patient consultations and traditional and religious healing; personal creative acts (for both patients and caregivers); and the history of healthcare choices and rationales among patients.

My data analysis shows health-seeking for mental and emotional distress among patients and their family members is socially layered and culturally negotiated. By highlighting sociomoral tensions inside mental health services and within clients' health-seeking narratives, I illuminate challenges to improving the accessibility and quality of mental health services in Batticaloa District and make practical suggestions given patient, family member, and caregiver informants' habits and interview responses.

Health-Seeking for Mental and Emotional Distress

Distress is a type of suffering usually associated with troublesome emotions such as worry, anxiety, sadness, depression, and built up stressors. In anthropology and transcultural psychiatry, distress is commonly understood as local expressions of social and moral disruptions in people's lives. Anthropologist Mark Nichter (1981) first uses the term "idioms of distress" to describe culturally-programmed ways of communicating suffering that includes contextual meaning with contemporary sources of stress and psychosocial conflict. Nichter's ethnographic research examines young Havik women in India who practice strict Brahman Hindu religion. Havik women are typically taught to be obedient, suppress feelings from an early age, serve elders, and leave disputes to their brothers.

In contemporary times, with Havik women having greater access to education and media, their expectations of marriage partners and families have changed. When young wives are introduced to husbands' families, they struggle with their low status within the family hierarchy and encounter jealously from their mothers-in-law or sisters-in-law. With greater geographic distances between marriage partners and kin, Havik women have less family support, allowing for few opportunities to discuss problems with their mothers, sisters, and close friends. Nichter shows that Havik women shows a range of expressions to communicate anxieties or stressors such as changes in weight, how they food serve to family members, more obsessional or ambivalent behaviors, vulnerability to supernatural agents, religious devotion, and illness. His research shed light on how patients, family members, and formal/informal caregivers respond to alleviate such idioms of distress. An examination of idioms of distress provides a lens through which we can understand local communicative features of suffering and sociomoral disruptions to people lives, identities, or statuses (Abramowitz 2010; Kirmayer 1984, 1989; Kohrt et al. 2014; Nichter 2010). Similarly, anthropologist and psychiatrist Arthur Kleinman (1988, 57) uses the term "somatization" to suggest personal and interpersonal problems that are demonstrated by physical expressions.

I utilize the concept of idioms of distress to examine suffering beyond biomedical categories of mental disorders to capture culturally- and locally-rooted expressions of suffering. Following medical anthropological approaches that examine human conditions of distress, this project examines "social suffering," the sociocultural determinants of and responses to people's suffering, particularly in contexts of collective violence and terror (Daniel 1996; Das et al. 2000, 2001; Farmer 2003; Feldman 1991; Green 1999; Kleinman, Das and Lock 1997; Scheper-Hughes 1992). These anthropological studies illuminate how cultural representation and collective experiences of suffering can affect and reshape individual subjectivity and interpersonal responses to social and political upheaval. Ethnographic research on social suffering demonstrates close connections between people's suffering and their ordinary, everyday experiences with social environments—i.e., issues not narrowly assessed through a macro-level, quantitative and/or biomedical lens (Das 2007; De Certau 1984). The concept of social suffering also highlights how political, technological, and bureaucratic responses to suffering may reinforce people's socioeconomic status and stressors. For this study, I focused on idioms of distress and conditions of social suffering that spurred clients to seek out various forms of healthcare. Given that distress is commonly linked to mental and emotional healthcare—whether it be professional, informal, indigenous, or traditional, I investigate how cultural and local concepts of distress are linked to mental health services and ways different therapeutic systems of knowledge influence clients' therapy management.

Cultural anthropology has a long history of examining health-seeking behaviors, processes, or strategies (Amarasingham 1980; Beals 1998; Chrisman 1977; Csordas and Kleinman 1996; Chrisman and Kleinman 1983; Nitcher 1980; Romanucci-Rossi 1977). Health-seeking studies are usually related to healthcare decision-making and choosing between different forms of healthcare. Thus, health-seeking processes undoubtedly relate to notions of medical pluralism (Baer 2011). The concept of medical pluralism in anthropology is not always is easy to define; it often takes on very simple, or very complicated, definitions depending on the nature of

the study (Baer 2011). Anthropological approaches to medical pluralism have focused on social analysis of and classifying different medical systems amidst global capitalist economic trends—e.g., local, regional, cosmopolitan, traditional, modern, and similar forms of medicine (Dunn 1998; Janzen 1978, 1987; Leslie and Young 1992; Stoner 1986). More recent research has examined the hybridization of local medical practices, particularly with greater availability and standardization of globalized biomedical technologies (Hampshire and Owusu 2013; McKay 2012).

Anthropological studies of medical pluralism and health-seeking have also focused on subjectivity, or, how people's notions of self and their suffering are shaped by encounters and experiences with pluralistic therapies such as biomedicine, traditional healing, ayuveda, and others (Halliburton 2002, 2003, 2004, 2005, 2009; Poltorak 2013; Taee 2017). Critical medical anthropological approaches have highlighted how individual and family patterns of resorts for health problems are shaped by class, caste, racial, ethnic, religious, and gender distinctions (Baer 2003; Broom, Doron and Tovey 2009; Crandon-Malamud 1986, 1991, 2003; Lock and Nichter 2002; Johannessen 2006). Building on these studies, I explore historical, global, national, and local therapeutic systems of knowledge and practice for idioms of distress that affect how and why clients make decisions to seek out different forms of mental healthcare.

Based on ethnographic data, and following a grounded theory approach, this project mainly utilizes interpretive and political economy theoretical frameworks to capture the multidimensionality of health-seeking processes for managing mental and emotional distress. In anthropology, subjects often are examined as adopting distinct symbolic connections to the world that allow for them to understand their experience (Biehl et al. 2007; Scheper-Hughes and Lock 1987). Building off hermeneutical and interpretative approaches to life histories (Bruner 1990; Crapanzano 1985; Geertz 1973, 1984; Ricoeur 1970), anthropologists position themselves to understand subjective life through capturing individual encounters with symbolic forms—such as words, images, institutions, and behaviors—within specific sociocultural contexts. By viewing

culture as dynamic, anthropological investigations provide important viewpoints for understanding how cultural and symbolic systems influence the perceptions, experiences, and behaviors of individuals.

First, I utilize Obeyesekere's concept of "the work of culture," the process by which symbolic forms at the cultural level are (re)created in the minds of people. "A symbol and a symptom," he writes, "contain both motive and meaning, but whereas a symptom is under the domination of motive, a symbol under the rule of meaning." (Obeyesekere 1990, 12). For example, in his book *Medusa's Hair*, Obeyesekere's (1981) ethnographic research on religious asceticism in Sri Lanka focused on individuals with irregular behavior, specifically the expression of matted hair. He assessed how the symbol of matted hair becomes transformed through painful emotional experiences of the individual, which allows for a "cultural patterning of the consciousness" (Obeyesekere 1981, 35). This cultural patterning, in turn, allows for one to fashion emotions and social identity through personal experiences. As Obeyesekere (1981, 35) describes, "The transformation of symptom into symbol is through the cultural patterning of consciousness, which in turn helps integrate and resolve the painful emotional experiences of the individual, converting eros into agape and patient in to priest." Obeyesekere (1981) suggests that among these religious ascetic-ecstatic, we can observe a transformation of irregular symptoms into personal symbols, which attacks any illusionary ideas about a radical divide between emotion (i.e., body) and custom (i.e., mind). Through dynamic ethnographic descriptions of historical and contemporary events, he captures symptoms or distress in various practices tied to sociocultural and institutional contexts. His research suggests that the symbol of matted locks—associated with a set of institutional rules and procedures—becomes manifested by personal motivations, becoming a personal symbol. My project builds on his, and other scholars (e.g., Chapin 2008; Hollan 1994; Janes 1999; Kakar 1978), analyses of the work of culture by focusing on: 1) organizational leader strategies to shape healthcare practices; 2) doctors' personalized efforts to develop therapeutic relationships with clients in mental health services; and 3) how patients and

their idioms of distress are symbolically transformed through strategic mental and emotional healthcare decision-making.

Second, building off Eric Wolf's (1983, 1990, 1999, 2001) ecological analysis of power, I analyze sociopolitical and temporal trends that shape state-based mental health services and individual health-seeking processes (Schneider 1995). First, in Chapters 2 and 3, this study analyzes sociocultural and political economic arrangements of mental and emotional healthcare at the regional (South Asia) and national level. Second, in Chapter 4, I assess organizational leaders and sociopolitical features that allocate and control resources in mental healthcare at the local level (Batticaloa District). Third, in Chapter 5, I review interpersonal interactions between doctors and clients within mental health services, and highlight opportunities and constraints for medical officers in treating clients. Fourth, in Chapter 6, I analyze individual health-seeking strategies by clients and their family members to cope with their suffering and everyday socioeconomic stressors. By analyzing different sociopolitical ecological levels of health-seeking processes for distress, I am by no means suggesting that these sociopolitical frames of analysis are fixed and do not shift, quite the contrary. Following Wolf, this study sought to understand what cultural practices are possible at given times and places, and how these practices operate at different social levels (macro, meso, micro). Given these different sociopolitical levels, I found local therapeutic systems of knowledge and practice do not operate in a consistent fashion, but instead, will shift as people of different backgrounds and status influence sociality.

Insights gathered from interviews and observations address stigma and accessibility issues associated with mental health services in low- and middle-income countries. In assessing sociocultural processes of health-seeking strategies, I analyze locally shared and personal rationales for accessing healthcare services given their idioms of distress and historical background. Specifically, I examine how and why people adopted or resisted different cultural practices for managing distress and ultimately sought state-run mental health services. In this study, both doctors and patients felt that socioeconomic issues that correlated with local forms of

distress went unaffected. They described how distress and problems facing patients went beyond symptom treatment, emphasized in clinic spaces in Batticaloa District. This study illuminates links between distress, patients' post-war socioeconomic situations, and how medicalized and bureaucratic routines of doctor-patient consultations do not address these issues. I discuss common struggles and forms of social suffering among patients given their identity (gender, class/caste, age, ethnicity, and religion), but also highlight personalized expressions of distress and strategies to manage given their history and background.

History and Context of Eastern Sri Lanka

The region called Batticaloa, also known as *Mattakkalappu* (or "muddy swamp"), is about an 8 to 10 hour bus or train ride from the capital Colombo (see Appendix B). The region, and the means of getting to Batticaloa, has significantly changed in recent years. It is now quite different from the stories told by locals and the ethnographic accounts of Dennis McGilvray, Mark Whitaker, Patricia Lawrence and others during the 1980s, 1990s, and 2000s. Before, transportation lines connecting the island were limited and disrupted by checkpoints and bombings and other war-related violence. With the introduction of new technologies, like cell phones and internet, and the response of international NGOs before and after the tsunami, Batticaloa is connected like never before. Even the tourist industry has significantly picked up in recent years, with most people visiting newly built high-walled resorts at Passikuda beach (actual name). Many tourists also travel to the southern east coast where Arugam Bay has become a popular spot, largely due to surfing. Eastern Sri Lanka has experienced a significant amount of social, economic, and political changes since the civil war ended a decade ago.

As its Tamil name suggests, Batticaloa District is an arid, lagoon-rich, and mostly flat region with fertile agricultural lands of irrigated rice patty fields. Historically, and currently, Batticaloa's main economic activity has been rice cultivation (McGilvray 2008; Ryan 1950). Other key economic activities include fishing, coconut plantations, and cashew production. The district is fairly densely populated with a population size of 515,857 people; however, 75% of the

population is considered rural (DCS 2012). It is mostly inhabited by two Tamil-speaking groups, Tamil Hindus and Christians (mostly Catholics and Methodists) (74%) and Muslims or Moors (25%) (DCS 2007). There are major socioeconomic disparities in the east when compared to the rest of the island. For instance, 4.1% of the total population in Sri Lanka live below the national poverty line, while 11.3% of the total population live in poverty in Batticaloa District (Kilinochchi is the highest at 18.2%) (DCS 2017). The district accounts for 7.2% of the total population living below the poverty line in Sri Lanka (DCS 2017).

It is important to note that Tamil-speaking populations do not make-up a unified social population. Instead, Tamil speakers are fragmented along many different lines. While living in Sri Lanka it was not uncommon for me to hear generalizations about people from the east as being backwards or lazy. I heard stereotypes like Tamil speakers from Jaffna, an important center of Tamil culture in Sri Lanka, spoke "correct" Tamil and were more intellectually attuned or dedicated to educational studies. Muslims or Moors recognize themselves as their own distinct ethnic group, differentiating themselves from other Tamil-speakers through language (placing high value on Arabic), religion, and their own unique history and representation. This can be partly evidenced by a Sri Lankan Muslim museum in Batticaloa District; it is only in the east that Muslims make up a geographically concentrated group—i.e., controlling parliamentary and local governing councils. Most Muslims in Sri Lanka follow mainstream Sunni Islam. Though the region has a rich history of intermarriages and strong interrelationships between Muslims and Tamils over the centuries (McGilvray 2008), with Sri Lanka's independence and schemes that settled Sinhala people and farms in the foothills at the district's edge, tensions between these ethnic groups have become heighted. In addition, since the 1980s, many Muslims and Tamils have sought employment in the Middle East in recent years. As demonstrated in the ethnographic research presented here, transnational labor has not only had major effects on Muslim towns and behaviors, but also on households and family dynamics.

When the Portuguese and Dutch arrived in Sri Lanka in the 1500s and 1600s, Batticaloa and eastern Sri Lanka were part of feudal territories of the Kingdom of Kandy. Local politics were controlled by the Tamil landowning caste, known as Mukkuvars (McGilvray 1982a), typically Tamil (Saivite) Hindus of matrilineal castes whose origins date back to the 13th century or earlier. They were granted this status for soldierly service in the armies of Magha—who claimed Kalinga ancestry and seized Polonnaruwa and other centers of Sinhala power with an army of Tamils and Keralans in 1215 CE (McGilvray 1982a, 2008). During Portuguese and Dutch colonial rule, interaction between northern and eastern Tamil-speaking populations were limited (Arasaratnam 1994).

Religious conversion to Christianity was a major concern for colonial powers. During their colonial rule, the Portuguese pushed to convert people to Catholicism, which is evidenced by the destroying of key religious sites in Sri Lanka—an estimated 500 Hindu temples were destroyed and more than 71,000 people were converted to Catholicism (Arasaratnam 1994). These efforts had little effect on the interior villages of eastern patty producing areas among non-Brahmanical practices of Hinduism. There was a resurgence of temples when the Portuguese left the island. At one point during Portuguese rule, Hindus and Buddhist aligned to fight off Christian conversions. The influence of Christianity on Tamil-speaking populations continued with American and British protestant missionaries arrival to Sri Lanka. These missionaries were important to establishing schools and the production of English speakers. Such efforts were mostly confined to the north, and the eastern populations did not have access to these educational resources, which contributed to eastern Tamils and Muslims being more peripheral under British colonial rule (Lawrence 1997b).

With the removal of the Dutch from the island, British rule started in 1796. By 1815, Sri Lanka (known as Ceylon) was unified under a European power for the first time. In 1873, Northern and Eastern Provinces were clearly defined, and access to education was expanded. Students from Jaffna found employment in influential offices of the British Administration,

bringing about an elite class of English-educated professionals (Arasaratnam 1994). Such opportunities were not expanded at the same pace in the Batticaloa region, which helped foster tenuous links between northern and eastern Tamils. Prior to and during colonialism, communal conflict was not based on the present configuration of Sinhala-Tamil ethnicity (Nissan and Stirrat 1990; Roberts 1997; Silva 1986; Spencer 1990). Instead, during colonialism, social disturbances were along religious lines (Spencer 1990). Colonialization introduced racial differentiation into governance. The British census labored to categorize the identities of the island population into distinct racial groups.

With independence from the British in 1948, political power in Sri Lanka resided with a small elite group of Tamil and Sinhalese English-speakers in the capital city Colombo (Winslow and Woost 2004). As the Sinhala claimed a majority of votes, they came to dominate the new democratic political system, creating disparities between the few western-educated elites and majority rural leaders entering parliamentary politics. Political party leaders began to resort to tactics that stroked communal passions (Wriggins 1960). Initial postcolonial tension between the Sinhala majority and Tamil minority increased due to discriminatory policies in the 1950s that aimed to establish a Sinhala hegemony over different sectors of society. For instance, the Sinhala Only Act in 1956 pushed for Sinhala being the only nationally recognized language in the country, thereby excluding many Tamil-speaking minorities. From 1956, Sinhala majority parties increasingly saw the Tamil minority as either enemy or ally, given how it played into gaining political control (Wriggins 1960). In a wave of Sinhala nationalism, the state also proclaimed Buddhism as the foremost religion in Sri Lanka, which led to developing and restoring Buddhist monuments, holidays, and construction of Sinhalese peasant settlements and colonies in Dry Zone areas. Some areas populated by Tamils.

Such state developments were viewed as a return to the admired ancient irrigation civilization of Sinhala people and made claims over ancient Buddhist sites (Moore 1985). In these areas, the Sinhala population increased tenfold in 30 years, increasing from 19% in 1946, to 83%

in 1979 (Peebles 2006). Following the official language act, non-violent protests were staged in 1956, 1957, and 1958, and resulted in outbreaks of violence (Nissan and Stirrat 1990; Tambiah 1986; Vittachi 1958). This scale of modern violence had yet to been seen between Sinhalas and Tamils. In response, the Bandaraniake (the Prime Minister)-Chelvanayagam (Tamil minority leader) pact was formed, it sought to correct over centralization of the administration and enable locally elected Tamil politicians to exercise control over their regional affairs. Given these concessions to Tamils, influential Buddhist monks protested. In May 1958, a train derailed in Batticaloa District, in which three train passengers and several individuals traveling on the road were killed. For the next two days, mob violence ensued in Polonnaruwa, in which politicians and local allies (Sinhalese land and irrigation department laborers) responded by assaulting, raping, and killing people (e.g., vehicles were stopped, and people were assaulted). Vittachi (1958) describes sugar cane fields being burned as Tamils hid inside. People would either perish in the flames or be cut down with knifes, swords, and clubs as they ran out. The pact was eventually abrogated in April 1958. In 1965, the Senanyake-Chelvanayakam pact was signed, which changed the former pact by substituting district councils for the regional councils (i.e., Tamil minorities have control over district affairs, but not regional affairs).

In 1972, the government instituted university policies aimed at increasing Sinhala representation in higher education. This led to a huge barring of Tamils from entering national universities. Such educational policies are said to be rooted in the high number of Tamil students attending universities as compared to Sinhala students (De Silva 2005). These numbers are likely attributed to the quality American Missionaries schools in Batticaloa and Jaffna (founded in 1813), in which educated and English-speaking Tamil civil servants were employed in proportionally higher numbers by the British colonial government than the Sinhalese (N. Wickramasinghe 2012). With Tamils being disproportionately represented in universities, such figures provided justification for the Sinhala government to implement discriminatory policies that barred Tamils from university admissions. Given these discrepancies in accessibility (rural),

education, and other social services between the east and other areas of Sri Lanka (both Tamil and Sinhala majority), large proportions of the population had lived in generational poverty in the Vanni and eastern costal region. Though some of these policies were eventually removed, the Sri Lankan government continued to push for a Sinhala hegemony at the expense of Tamil, Muslim, and other minorities. Many frustrated young Tamils lost interest in fighting battles in formal political arenas in a Sinhala-dominated government (Thiranagama 2011). With education being highly valued by Tamils, particularly where English-speaking American and British school systems had been established, such discriminatory policies contributed to many Tamil youths joining separatist militant groups in the 1970s.

With rising unemployment and the Janatha Vimukthi Permauna (JVP) violent uprising in 1971—a group initially made up of Sinhala students pushing for Marxist type reforms, Sri Lankan society became increasingly fractured and militarized. In 1976, the Liberation Tigers of Tamil Eelam (LTTE) was formed, headed by the powerful leader Prabhakaran. With greater militant activities by Tamil parties, the Sri Lankan government passed the Prevention of Terrorism Act in 1978. This Act enabled police and military forces to hold suspected terrorists without due process indefinitely (Whitaker 2007). In the 1977 general election, Sri Lankan Tamils overwhelming voted for politicians running on a platform for a separate Tamil state. Tensions between Tamils and Sri Lankan security forces amplified further with the burning of the Jaffna library in 1981—an important cultural site for Tamils in Sri Lanka containing ancient palm leaf inscriptions and other precious items.

The anti-Tamil riots of July 1983 was a crucial point of unprecedent violence, and mark the beginnings of the civil war. With assistance from India's Research and Analysis Wing (RAW)—providing training camps, firearms, explosives, and communication equipment, the LTTE stepped up attacks on Sri Lankan military targets (Gunaratna 1993). In 1983, the situation developed into a civil war when the LTTE attacked a military convey and killed 13 soldiers. This event led to anti-Tamil riots in Colombo and throughout the island on a large scale that had not

been seen before. State estimates suggest that around 300 Tamils died in these riots, but other estimates suggest higher death totals of 2,000 to 3,000 (Tambiah 1986). Moreover, numerous scholars suggest that government forces looked the other way while property was destroyed, and people were beaten or killed (Bastian 1990; Daniel 1996; Kanapathipillai 1990; Tambiah 1986). Following the riots, the number of fighters in Tamil militant groups increased by the thousands. Thereafter, we begin to see massive arrests, detention camps, and disappearances happening. With such abuses, more Tamils took up arms.

By 1986, displacement intensified, with estimates of 130,000 fleeing to India and 75,000 seeking refuge in other parts of the world (Lawrence 1997b, 68). In 1987, India entered as a conflict mediator. This agreement was called the Indo-Sri Lanka accord and led to the deployment of the Indian Peace Keeping Forces (IPKF) in Sri Lanka that same year. From the outset, the LTTE rejected the accord entirely. As a result, fighting ensued between IPKF and the LTTE, which led to widespread sexual violence by IPKF. IPKF presence further displaced Tamils living in the north and east. The IPKF also played a damaging role in the relations between the LTTE and the Muslims in the east. After several attempts to reach an agreement for Tamil autonomy in the north and east, these efforts were quickly evaporated by the LTTE resistance, which led to a further increase in violence, sexual assault and rape, and militarization in Sri Lanka (Thiranagama 2011). Numerous massacres in the east occurred after 1987. In some cases, entire villages were murdered and burned (D. Somasundaram 2007).

Following numerous military and political setbacks, in 1989, India began to pull IPKF soldiers out of Sri Lanka. In order to replace the IPKF troops, India's RAW formed the Tamil National Army (TNA), who practiced forced conscription. Tamil youths were taken out of their homes, abducted at checkpoints, or forced into vans or trucks. Even schools served as collection points (Trawick 2007). During TNA conscriptions, families sent thousands of children abroad, to safer places outside the east and north, or hid in Muslim enclaves in Batticaloa District. Not long

after it was established, the TNA was annihilated by the LTTE, which led to a massive transfer of weaponry.

During the war there were massive displacements of people from the Tamil-speaking east coast and northern peninsula in 1990 and from the Vanni region in 1995 as well as 2009. After key events, a major displacement came in 1990 when approximately 75,000 Muslims were forced out of northern areas (Thiranagama 2011). The LTTE declared Muslims were not part of the separatist Tamil project and wanted them ethnically cleansed from the area. Stories of these expulsions describe people only having a few hours to grab important items they could carry, leaving their house and property (Thiranagama 2011). Some people were robbed and looted by LTTE as they moved south. In addition, Tamils and Muslims had left the island throughout the war causing major "brain drains" in different labor sectors of society (like healthcare) and forming diaspora communities in Toronto, London, and other countries and cities.

On December 26, 2004, a tsunami struck 70% of Sri Lanka's coastline, killing an estimated 35,000 people. In Batticaloa and Ampara Districts alone, over 13,000 people were killed (Galappatti 2005; Gamburd and McGilvray 2010). After a series of ceasefires and internationally brokered peace accords, civil war continued to rage in Sri Lanka. A major turning point came in 2004 when Colonel Karuna, the leader of the LTTE eastern command, broker a deal with government, thereby breaking away from LTTE forces. Given his knowledge of LTTE operations, routes, weapons caches, and other strategically important information, LTTE begun to suffer large scale defeats. In 2009, the government forces stepped up campaigns to eliminate the LTTE forces. During the period between January to July 2009, when the LTTE surrendered, numerous civilians died, with estimates as high as 40,000 people died in the final months of the civil war (OHCHR 2015). This horrific violence and loss of life is still a major contention point between Sri Lanka, the UN, and westernized democracies, with such international governing bodies wanting someone to be held responsible for recent and past human right violations and massacres (Clarance 2007).

Earlier ethnographic research in the eastern region concentrated on studies of caste, ethnomedicine and fertility, kinship and marriage, matrilineal law, temple politics, and religious rituals (McGilvray 1973, 1982a, 1982b; Whitaker 1999). In the matrilineal kinship system, a vast bulk of parents' property (house and lands) are used as dowry, leaving sons to seek fortunes through marriage alliances with women who have such resources (McGilvray 1989). Son-in-laws usually take residence in the house of his wife, her parents, and her unmarried siblings. However, after a few years, the in-laws move to another residence close by, which is intended as a dowry house for the next daughter to be married. Clearly these traditional patterns of settlement are affected by socioeconomic strains in single parent or impoverished households. Married sisters will often share their domestic burdens, providing social support for one another. McGilvray's research on ethnomedicine shows strong links in knowledge and practices between Muslim and Tamil like dietary practices, gender and sexuality, female puberty rituals, and cultic practices of worship to fierce local female deities such as Kannaki and Pattirakali (McGilvray 1982b).

As noted by Lawrence (1997b), earlier ethnographic research did not capture socioeconomic disparities and the increasing militarization and ethnic conflicts and tension between all groups in the region. My research builds on anthropological studies of the self, or individuality, in South Asian and Sri Lankan contexts. Early approaches in South Asia studies emphasized collectivity and hierarchy over individuality and personal agency (Dumont 1970; Marriot 1976, 1990; Marriot and Inden 1977), arguing that cultural values of the self are lacking in South Asia because people derive their sense of identity through simplistic notions of hierarchy and caste relations (Busby 1997; Mookherjee 2013; Sokefeld 1999). In an effort to avoid and critique static, self-collective generalizations about South Asian peoples, anthropologists have turned to the study of individual sensibilities and life stories to recognize and explore the fluidity of individuality (Arnold and Blackburn 2004; Daniel 1984a; Mines 1988).

In contexts of political violence like Sri Lanka, anthropologists have illuminated various forms of self-fashioning (constructing one's identity to socially acceptable standards) and

meaning-making acts by which people manage the uncertainty of war and disruptions to their social and moral worlds (Lawrence 2010; Thiranagama 2013; Thurnheer 2009, 2014; Walker 2013; Whitaker 2007). For example, Lawrence's (1997a, 1998, 2000) ethnographic research on a female oracle in Batticaloa District elucidates how fortune-telling activities provide worshippers with socially-permitted opportunities to express unresolved pain over the death and/or arrest of family members in politically oppressive conditions of civil war. Similarly, Derges's (2009, 2013) ethnographic research in northern Sri Lanka on *thuukkukkaavadi*—a Tamil body ritual of religious devotion where devotees are pierced with multiple hooks and then suspended from a tractor vehicle or pulled by a person for extended periods of time—reveals social opportunities for residents to express their anger and distress. This ritual allows for devotees to publicly give meaning to their suffering and achieve states of euphoric transformation, which, in turn, helps participants to recover, cope, or heal from torture, painful loss, and shattered social relations (see also Kapferer 1979, 1983; Nabokov 2000; Obeyesekere 1981; Vogt 1999). Still lacking in the anthropology of South Asia and Sri Lanka, however, is research on the self and meaning-making practices within professionalized biomedical clinics and interactions.

Study Results and Contributions to Anthropology and Global Health

Given this project's design, and method for recruiting health-seekers, every client interviewed sought allopathic/biomedical psychiatric services to manage their mental and emotional distress. Many were unable to alleviate their distress through religious, traditional, or formal indigenous medicine alone; or, they bypassed these forms of healing and went directly to state-run allopathic/biomedical hospitals. They negotiated with various healers in Batticaloa District, and eventually accessed allopathic/biomedical services, at great risk of embarrassment and shame to themselves and their families. Those accessing state-run mental health services were often at social, moral, and emotional extremes, where fundamental roles within their families and communities deteriorated due to war-related violence, alcoholism, poverty, transnational labor, and other socioeconomic determinants of distress. Thus, as part of the health-

seeking process, patients learned to recreate themselves for family and friends, as well as to adapt to a new normal. These narratives include the use of biomedically-based and local therapeutic systems of knowledge and practices that are thought to alleviate idioms of distress, and document personal rationales and meanings of suffering.

My fieldwork indicates there are clients with numerous types of idioms of distress and socioeconomic struggles in post-war Batticaloa District, stressors that extend well beyond biomedical treatments and psychopharmaceuticals. Using qualitative methods, I identify complex, yet shared, sets of similarities involved in strategic healthcare decisions and sociocultural determinants of distress. In Chapter 6, I profile four categories of clients that shared complex forms of social suffering: women headed households, transnational labor, sexually-rooted anxieties, and transgenerational poverty. During fieldwork, I documented local idioms of distress, such as thoughtfulness and sleeplessness, as well as identified socially vulnerable groups of individuals seeking state-run mental healthcare in Batticaloa's shifting post-war social and economic landscapes.

Within these health-seeking narratives, I discuss stressors and personalized strategies adopted by clients to alleviate and cope with distress. I also document ways they are impacted by major deficiencies in bureaucratic and medicalized approaches to treating mental and emotional distress. A primary issue, I contend, is a lack of outpatient services that could foster stronger therapeutic relationships with doctors, as well as build upon holistic approaches to treating individuals apart from pharmaceuticals. Within the chapters of this dissertation, I explore the complicated narratives of individual clients and mental health staff that have weathered through social transitions of war and disaster, organizational leadership changes, and dwindling human and material resources.

My ethnographic research reveals that residents in Batticaloa District who sought out treatments for problems considered "mental" and "emotional" did not access professionalized ayurveda/siddha/unani doctors. Though patient informants did utilize indigenous doctors for other

health issues (dental, fevers, skin problems, etc.), all 23 patient respondents did not access these doctors for the idioms of distress tied to their treatments at state-run mental health services. Moreover, all caregivers I interviewed—including two indigenous formal physicians and two traditional healers (paricari)—suggested that their patients were not utilizing professionalized indigenous medicine to manage distress. Most informants (15 out of 23) first sought out religious, spiritual, and/or traditional healing to address their problems (see Appendix C). When reviewing the history of mental and emotional healthcare in India and Sri Lanka, I suggest clients' efforts to treat and heal such problems are historically tied to South Asian ideas that conceptualize mental illnesses as spurred by supernatural forces extended beyond individualized bodies, illness, and biology.

My primary argument for this dissertation project is built on four secondary arguments in Chapters 2-5. First, in Chapter 2, I argue that traditional healers who treat mental and emotional distress are largely disconnected from state-run mental health staff and services in Batticaloa District; what Dr. Sivalingam, a local paricari described as "we speak through patients." Such sociocultural disconnections between different healers and doctors affected clients' therapy management and how and why they accessed different healthcare providers. South Asian and Tamil-speaking therapeutic systems of knowledge for explaining and treating distress are heavily tied to externalized supernatural forces, kinship and community relations, and place (home and soil) (see Appendix D). My interviews and observations with paricari Dr. Sivalingam illuminate how his healing practices—e.g., saying mantras, blessing water, giving herbal liquids—helped locals manage their distress in the east through protecting them or expelling evil spirits from their bodies. Through analyzing a client's health-seeking narrative, Marliya, I highlight personalized strategies and rationales that reveal how sociocultural disconnections between healthcare providers are manifested in health-seeking processes. Such ethnographic evidence of traditional healers and clients' health-seeking narratives builds on anthropological studies of global health

and medical pluralism. Specifically, the role of traditional healers in filling in human resource gaps or task shifting of staff to manage these gaps.

Second, I argue that state resources have fluctuated and there has been a consistent patient population rise since the introduction of westernized psychiatry during British colonial rule. These limited and fluctuating resources have contributed to negative, generalized, and homogenous ideas about the mentally ill and state-run mental healthcare: a symbolic condensation of notions of mental illness, madness, and distress in local cultural and bureaucratic and medicalized processes. I use Dr. Ramesh's phrase, "the Angoda model," to describe the complex history of mental healthcare practices in Sri Lanka and the ways in which westernized psychiatry is regionalized, nationalized, and localized.

Third, I discuss two mental health leaders and their personal strategies to build mental health services in the east. However, there lacks development of outpatient services, making it difficult to follow a recovery-based approach, or Dr. Ramesh's adaptation called "friendly services," that addresses patients' needs beyond drug treatment of symptoms and maintaining compliance. This chapter is crucial in understanding how individual leaders shape mental health services amidst humanitarian relief and global mental health programs. This research adds to studies of global mental health campaigns, and aims to understand which services are sustainable or have dwindled due to changes of leadership and shifts of resources in local settings.

Fourth, I argue there is de-skilling of medical officers amidst bureaucratic routines of doctor-patient consultations. In Chapter 5, I argue that bureaucratic routines focused on drug treatments and compliance in doctor-patient interactions threaten to de-skill medical officers and their ability to understand and address their clients' social determinants of distress though therapeutic relationships, talk therapy, traditional healing, and other pluralistic therapies that go beyond biomedical standardization of state-run mental health services.

There were tremendous environmental strains of civil war in which people living in the north and east experienced a collective trauma that expands beyond individual suffering and the

treatment of individuals. Now, there exists more individualized suffering (by individualized I am referring to both patient and family members), and status and rank have become prominent features of suffering. Attempts by mental health staff to practice a more liberalized model of psychiatric care ("friendly services") that extended beyond the medical model have dwindled in the post-war context.

Summary of Chapters

In Chapter 2, I address indigenous medicine and traditional healing practices that inform South Asian and Tamil-speaking people's understandings of mental and emotional health. An historical analysis reveals the major role of traditional healers and indigenous medicine, who seek to mediate clients' metaphysical links to their kin, evil forces, and places. However, these traditional healers and practices are often criticized by allopathic doctors and largely disconnected from state-run mental health services in Batticaloa District. I focus on two narratives: a traditional healer, Dr. Sivalingam; and a client, Marliya. Marliya's health-seeking experience shows disconnected therapeutic systems of knowledge and practice for treating her distress.

In Chapter 3, I discuss the origins of westernized psychiatry in Sri Lanka during British colonialism. With little means of treating mental illness in the 19th century and in the first half of the 20th century, most psychiatric practices focused on institutionalized and custodial forms of care that included rewarding and punishing behavior, occupational therapy, use of opium and cannabis, and confining patients in asylums. After independence and during the second half of the 20th century, asylums became more liberalized, allowing voluntary admissions with the development of psychiatric technologies (e.g., the first psychotropic drugs in the 1950s). A history of fluctuating material and human resources, and overall negative generalizations linked to state-based mental healthcare, have contributed to the stigmatization of services and marginalization of people managing forms of mental and emotional distress.

Chapter 4 explores the development of mental health services in Batticaloa District and the key leaders that have shaped mental health practices. I examine two leaders, Drs. Ramesh and

Chamil. Dr. Ramesh's leadership abilities and vision challenged historically rooted dominant models of care—what he called the Angoda model—within Sri Lanka's mental health system. He established inpatient and outpatient services and bolstered other services like outreach clinics and community-based programming throughout Batticaloa District during the civil war and after the tsunami.

In Chapter 5, I outline four types of social interactions between doctors, staff, clients, and family members: ward (inpatient), clinic (outpatient), counseling/psychotherapy, and home visits. I discuss how social and economic changes happening within post-war eastern Sri Lanka are negotiated amongst overstretched and bureaucratic services. As such, there are limited opportunities for medical officers like Dr. Pradeep to develop strong therapeutic relationships with clients, have long discussions with clients, and utilize their skills that extend beyond medications and hospital spaces. To manage overstretched mental health services and limited human and material resources, current mental healthcare practices follow bureaucratic routines that may de-skill and homogenize experiences of mental illness through narrowly assessing the risk and stability of clients, documentation and quantitative measurements of clients' care, and family management of drug compliance.

Chapter 6 identifies four types of clients that shared experiences of social suffering. I analyze clients' negotiations with different therapies and local notions of shame and stigma associated with mental illness and local and professionalized forms of mental healthcare. I investigate patients' health-seeking processes (before, during, and after medical care), therapies for coping with distress, and individual learning and creative acts. I identify health-seekers' socioeconomic stressors and patterns of resort among pluralistic therapies. I illuminate ways clients faced challenges in addressing their social determinants of distress within current bureaucratic and medicalized services. In Chapter 7, I conclude with main arguments, contributions to anthropological and global health literature, and recommendations for improving mental health services in Batticaloa District and elsewhere.

Chapter 2: "We Speak Through Patients": Indigenous and Traditional Healing for Mental and Emotional Distress

Dr. Sivalingam's father worked as a *paricari* or traditional healer for 51 years before he died in 2015. His father had a well-known reputation in eastern Sri Lanka and elsewhere for healing mental and emotional illnesses. Dr. Sivalingham proudly told me people even came from foreign countries to get treatment from his father, and now him. During my fieldwork, I first learned about his father from doctors and staff in Batticaloa District's mental health units after I inquired about traditional healers. He developed a reputation among mental health staff for working with Dr. Ramesh at the start of rolling out and expanding mental health services in the district in 1999. When I asked Dr. Sivalingam about his father's relationship with Dr. Ramesh, he said, "Before Dr. Ramesh, my father would chain up as many as 10 patients at a time." From what I observed, Dr. Sivalingam still sometimes chains people to the healing center he operates next to his residence. In fact, when I first visited his healing center, he had a young man chained by one leg to the building. I believe Dr. Sivalingam locked him up to treat a ganja addiction. Such practices and others (e.g., whipping), regardless of intent, have largely driven mental health staff's negative opinions of traditional healers treatment of mental and emotional distress.

Later, I learned from Dr. Ramesh that he never actually had the chance to meet Dr. Sivalingam's father. When I asked Dr. Sivalingam if he ever met or worked with Dr. Chamil, the current consultant psychiatrist in Batticaloa District, he said, "I did not meet him face-to-face, but we speak through patients." I interpret his phrase "we speak through patients" as highlighting social disconnections between psychiatric and traditional caregivers, and also to illuminate patients' negotiations with plural therapies and cultural ideas about distress that are involved in their healthcare decision-making.

Although traditional healers play a crucial role in treating mental and emotional distress within Tamil-speaking communities in the east, according to my historical analysis and ethnographic research, state-run mental health services remain largely disconnected from

paricaris. I problematize and highlight this disconnect through interview responses, discussions, and observations. These discussions often revert to uncommon, yet very salient, potential forms of "treatment" that include abusive practices such as whipping, starving, and tying up to expel evil forces from individuals. Many physician informants emphasized that such practices were inhumane and worsen clients' mental and emotional stability. Given cultural ideas regarding metaphysical links between people's distress, evil forces (external features, evil eye, ghosts), and places (home, village, soil) among South Asian and Tamil-speaking populations, traditional healers in Batticaloa continue to provide a key role in mediating these symbolic links in clients' everyday lives.

In this chapter, I discuss particular cultural ideas of South Asian, Sri Lankan, and Tamil communities that provide local and regional understandings of the self and mental and emotional health. Out of the 23 patients I interviewed for this study, 15 sought out traditional or religious forms of healing prior to accessing state-run mental health services. Information about the sequence of healthcare choices among clients is shown in Appendix C. Such actions are very common given my observations of and discussions with Batticaloa residents in and out of hospital settings. Those seeking services spend many months and large sums of money at traditional healer sites before going to state-run or private hospitals staffed with psychiatric doctors, possibly because of the historically rooted stigma and negative opinions tied to state-run mental health services.

I begin this chapter by discussing the historical trajectory of mental and emotional healthcare on the Indian subcontinent and Sri Lanka, particularly for Tamil-speaking populations. Given the fairly recent developments of mental health services in the east, I suggest cultural practices for coping with mental and emotional problems are fundamentally rooted in the supernatural. Here, I present data showing how problems are materialized and understood through metaphysical and dynamic connections between an individual and evil forces, body humors, kin, and home or place. As discussed by South Asian scholars (Fernando 1991; Kakar 1982;

Obeyesekere 1981; Pugh 1983), people in India and Sri Lanka may seek out a variety of traditional and religious healers to bring together or balance separated or disrupted links with ghosts, bodies, and settings. Specifically, I focus on how experiences of mental and emotional distress are externalized and conceptualized beyond the body of the individual.

I analyze Dr. Sivalingam's healing practices and his efforts to protect or expel evil spirits from within and outside the body. I also discuss Marliya's health-seeking narrative, a Muslim client in her forties who, prior to accessing mental health services at Hospital B, negotiated with different paricaris who had both negative and positive effects on her idioms of distress. Using interviews and observations, I document ways traditional healers provide residents in the east with reassurances amidst local social disruptions in their lives and their belief systems.

An analysis of traditional healing and global health programming intersects with the anthropological literature addressing medical pluralism. Medical pluralism often refers to multiple forms of medicine and healing in a given cultural context. Anthropologists have played a key role in researching, analyzing, and classifying different medical and healing traditions (Beals 1998; Dunn 1998; Janzen 1978, 1987; Stoner 1986). Efforts to include traditional healers in international public health planning date back to the WHO/UNICEF Alma Ata meeting in 1978. This event produced one of the first international declarations to focus on "health for all" through the development of primary care services in developing countries (Orr and Bindi 2017). Much of the recent discourses surrounding GMH and traditional healing have focused on task shifting and the ways healers can fill human resource gaps in services addressing mental and emotional problems via providing counseling and other community-based programming (Incayawar 2009; Incayawar et al. 2009; McInnis and Merajver 2011). My research focused on state-run biomedical/psychiatric services, therefore, I focus on psychiatric caregiver's perceptions of and connections with traditional or religious healers. Specifically, I highlight caregivers' limited relationships with, and allopathic physicians' negative opinions of, healers (or priests) because

clinical evidence suggested patients were physically abused, financially extorted, or inhumanely treated.

If networks can be built between traditional healing and allopathic doctors, and training and oversight ensure best practices and safety, doctors could provide referrals to quality traditional healers that do not perform abusive practices. Building such referral networks would help fill psychosocial support gaps that are evidenced and discussed at length in the dissertation chapters that follow. In the following section, I discuss the early history of mental healthcare and cultural ideas regarding mental illness in South Asia. Based on my review of relevant history and literature, I present cultural knowledge and practices for alleviating mental and emotional distress in Tamil-speaking populations as external from individual bodies; phenomena commonly understood to manifest from: 1) external supernatural forces, 2) disruptions of kin relations, and 3) the body's connection to home and place. I show the importance of these three sociocultural factors to mental and emotional health in Tamil speaking populations in eastern Sri Lanka. After this section, I discuss Dr. Sivalingam's healing techniques that mediate and protect clients' metaphysical connections with evil spirits, kin, and home.

Sanskrit-Based Hindu and Ayurveda Medicine

There is little historical evidence regarding mental illness and its treatment in precolonial Sri Lanka and broader India. The earliest evidence of religious and medical practices for mental healthcare come from early Sanskrit-based texts known as the Vedas, written between 1500 and 1000 BCE. In these texts, diseases and erratic behaviors are commonly linked to supernatural causes such as punishing gods/demons, or an overall disruption of one's moral cosmology in general (Basham 1998). The Rig-Veda is often viewed as the most important and sacred of the Vedas. Verses of the Rig-Veda are seen in all other Vedic collections. However, verses in the Atharva-Veda contain the origins of ayurveda medicine, and provide the earliest evidence of discussing insanity or possible forms of mental illness and distress on the Indian subcontinent (Bhugra 1992).

A charm or hymn against insanity in the Atharva-Veda mentions two types of insanity (Zysk 1985, 62). The first type is called *unmadita*, which refers to abnormal behaviors brought about by a person's violation of divine taboos. The second type is called *unmatta*, which suggests non-sensible behaviors spurred from demon possessions (*raksas*). In addition to detailing the benefits of herbs and other plants (called *virudh*), the Atharva-Veda outlines mantras or medical charms (*bhesaja*) that enact spells to achieve various aims such as curing diseases, exorcising demons, or protecting oneself from supernatural harm (Basham 1998; Subbarayappa 2001; Zimmer 1948). According to Zysk (1985), insanity was considered like death because the mind had left the body. A healer's primary role was to return the mind to the body (Rao 2002). For a case of *unmadita*, for example, the healer may make offerings to the gods to appease them. Given that Vedic descriptions and categories for madness were exclusively connected to supernatural or divine forces, scholars suggest that there was not a marked difference between diseases and demons, highlighting a significant distinction from the later categories regarding mental health used in ayurvedic medicine (Zimmer 1948).

Building off the ideas in the Atharva-Veda, around 600 BCE we begin to see the origins of what is known as Ayur-Veda ("Knowledge of Life or Longevity") medicine. Ayurveda is crucial to understanding South Asian people's thoughts on health, illness, the body, and the concept of a person (Kakar 1982: Zimmermann 1995, 1999). The earliest writing on ayurveda come from Caraka (around 150-100 BCE) who discussed humoral theory and medical classifications and techniques, including diagnoses and treatments for mental illness (Bhugra 1992). Caraka Samhita ("Caraka's Compendium") provides the beginning of classical medicine in India, in which there is a divergence between demon and disease (Caraka 1998; Wujastyk 1998). In the ancient writings of Caraka and other ayurvedic scholars, diseases and demons are differentiated, and a humoral theory of the body is developed. Such differentiation was partly due to the influence of Samkhya and Vedanta schools of philosophy in which new understandings and explanations for natural phenomena were introduced through conceiving the soul/mind and

matter/body as either the same substance (Vedanta) or different substances (Samkhya). These schools of thought influenced ayurvedic ideas regarding balance, change, matter, and the universe, particularly *pancha-bhuta* theory. In ayurveda, pancha-bhuta theory suggests the universe is constantly in flux and composed of five elements: ether (expansive, empty, and without resistance); air (the movement of the system); fire (friction, govern metabolic processes); water (key to the body's composition and function); and earth (soil, dense, hard elements) (Kakar 1982).

Ayurveda groups these five elements into three basic types of "energy" called humors (*tridosa*): *vata* (ether and air, subtle energy associated by movement); *pitta* (fire and water, the body's metabolic activity); and *kapha* (earth and water, bodily structure, holds things together) (Lad 2002; Pole 2006; Obeyesekere 1970, 1977, 1998). According to humoral theory, disease and illness are caused by a disruption or imbalance *(gunas*) of these three body humors. Ancient Indian doctors believed that physical and mental health is due to a state of dynamic equilibrium between the three humors, as well as between three mental qualities mediating the connection between the soul (*atman*) and body: *satva* (ego, knowledge, consciousness); *rajas* (action, passion, aggression); and *tamas* (inaction, confusion, sadness, excessive sleep) (Kakar 1982). Treatments were developed with regard to connections between the three body humors and mental qualities, as well as substances and evil forces exterior to the body.

In the early ayurvedic texts, mental illness (or *unmada*) is linked to an imbalance of humors and stressful life situations, inappropriate diet, disrespect towards the gods/teachers/the twice born, and/or mental shock due to excessive fear or joy (Bhugra 1992, 1996; Fernando 1991; Obeyesekere 1977). Five types of *unmada* are classified as either an endogenous or exogenous disruptions of humors (Fernando 1991). In ayurveda, the heart is the center of a network that carries energy and nutrients to different parts of the body. As such, mental illness is often viewed as rooted in the body, somatic-psycho rather than psycho-somatic (Kakar 1982; Obeyesekere 1970, 1998). Those receiving services were diagnosed using preliminary stages of insanity

(referred to as *mada*): premonitory symptoms (fatigue, emptiness of the head, unconsciousness and anxiety) and various distinctive behaviors including perversions of the mind, or false memories. Other main causes of unmada are "exogenous agents," or possessions by good or evil spirits (*devonmada* or *bhutonmada*). Supernatural beings may enter the body invisibly and suddenly, cause disease without possession, or make someone more prone to illness. Exogenous factors that may predispose a person to forms of madness are: special days (e.g., full and new moon days); hurting or harming gods, cows, Brahmanas and ascetics; apathy; or letting their body odors be sniffed (Bhugra 1992).

Ayurveda provides physical treatment of the psyche and connects foods to emotions. Such cultural ideas are tied to traditional healing practices and local ideas regarding mental and emotional health in eastern Sri Lanka. Caraka suggested that right conduct or behavior (e.g., diet, exercise, moral duties) could help preserve physical and mental health. Ayurveda focuses on achieving a holistic conception of health, on the person rather than the disease. Medications are given a secondary role, and the individual as a whole is examined in respect of his or her disease (Abhyankar 2015; Basham 1998; Gautam 1999; Subbarayappa 2001).

Ayurveda doctors and traditional healers aim to purify, pacify and remove the cause of distress (Kakar 1982), going beyond curing the disease to promoting longevity of life. Indigenous and traditional doctors/healers often match diet and drugs to the patient's temperaments and humors, with only few differences regarding "physical" and "mental" illnesses. Insanity caused by wind (*vata*), for example, calls for physicians to prescribe oily drinks. For phlegm and bile illness, doctors ask patients to vomit and purge (oiled and sweated) (Wujastyk 1998). They may also prescribe spiritual therapy that includes mantras, wearing talismans and gems, auspicious offerings, religious activities (chanting, pilgrimage, etc.), and/or "shock treatments" that might involve throwing a distressed person in a well and keeping them hungry until emaciated, or showing them something startling (Wujastyk 1998). Healers learn how to "see" the state of a person's five *bhutas*, three humors, and three mental qualities. They do this through examination

of pulse (*nadi*), skin color, and eight other anatomical features (Fernando 1991). Part of an ayurvedic diagnosis involves the deduction of a person's personality type and environmental conditions—i.e., what is traditionally expected for obtaining good health, morality, or diet. Given the diverse populations and broad scope of mental and emotional healthcare in South Asian societies, mental health outcomes are often linked to the province of many healers (exorcists, mystics, astrologers, etc.) (Basham 1998; Jaggi 1977).

Tamil-Based Siddha Medicine and Folk Concepts

Ayurveda and siddha medicines have very similar theoretical foundations but differ in practice of therapeutics as well as language and location of origin. The origin of siddha medicine (*citta vaittiyam*), a Tamil-based medical system, remains unclear. According to Zysk (2009), numerous texts on siddha medicine that solidified it as a medical system were not written until around the 16th century. Siddha as a medical system likely occurred earlier, but we lack historical evidence. The first mention of ayurveda (*ayulvetar*) medicine appears in the well-known Tamil epic called *Cilapattikkaaram* ("Tale of the Anklet"), dated around the mid-fifth century CE (Zysk 2009). There is also mention of the three humors in *Tirukural*, a collection of Tamil poems discussing love, society, and duty, dated between 450-550 CE (Zvelebil 1973, 1974). The epic mentioned 104 herbs, 10 couplets on disease and treatment, and discussed dietary habits that should be followed for good health. One of the earliest descriptions of mental illness is in *Manimeghalai*, it followed the Cilapattikkaaram, and includes an encounter between a heroine and a wandering man who appears to be mentally disturbed (O. Somasundaram 2002; Somasundaram and Murthy 2016).

In a mythical fashion, the sage Agastya is often attributed as the founder of the Tamil siddha cult and the father figure for Tamil medicine, literature, and grammar. Tirumular, his pupil, was one of the earliest Tamil siddhas and invented siddha medicine. He wrote, "Medicine means the prevention of physical illness; medicine means the prevention of mental illness; prevention means to avert illness; medicine therefore is the prevention of death" (Zvelebil 1973,

124). A siddha was a person who obtained the highest aims in spiritual efforts. They were freethinkers, spoke against caste, and sought liberation (*moksa*) from rebirths. To siddhas, the body must remain in perfect condition for as long as possible to aid in meditation leading to *moksa* (Zvelebil 1973, 31). The core of siddha medicine is alchemy, and exists in a similar form to the traditions of ancient Greek, Chinese, and Arabic alchemy. For example, there is an important mysterious substance known as *muppu* that transforms metal into gold, makes the human body deathless and youthful, and provides links to immortality (Weiss 2004).

Siddha medicine was also influenced by pancha-bhuta and three humor (*muppini*) theories. In Tamil, these are: *vaatam* or *vaayum* (wind or motion), *pittam* (bile or heat), and *cileerpanam* or *cileettumam* (phlegm or the connective). Both ayurveda and siddha suggest humors can vary in intensity at childhood, adulthood, and elderhood, but the traditions differ in what humors are dominant during these different life stages. Siddha physicians examine a patient through eight anatomical features (*envagi thaervu*) in relation to the three humors. They also place high importance on the examination of pulse for diagnosis and prognosis (called *natiparitchai*) (Daniel 1984b). Siddha medicine's focus on pulse was likely the influence of Arabic and unani medicine. Unani medicine arrived in Sri Lanka and India centuries ago (after 700 CE) through (ancient) Arab trade routes and Muslim rulers on the Indian subcontinent around the 13th century CE. Unani's Greek and Arab roots introduced new drugs (mercury and opium), which were crucial to siddha medical practice. Like ayurveda, siddha focuses on positive health and the goal of disease and illness prevention (Anandan 1983).

Cultural ideas regarding humors and substances in ayurveda, siddha, and unani medicines have impacted folk-related health knowledge and everyday practices in Tamil communities. Scholarship and ethnographic research on folk ideas and beliefs systems in Tamil-speaking populations in India and Sri Lanka have demonstrated how emotions, feelings, and notions of health are highly connected to other family members, deities and demons, one's house and soil/land, caste area, and village. Blood (*irattam* or *utaram*) is seen as an important substance for

caste purity and rank, and it can be weakened by impurities and become over heated (called *irattakkotippu*) (McGilvray 1982b).

Tamil-speaking populations living in south India and Sri Lanka often believe that one's diet, environment, and daily routines have effects on humors and internal states of the body (Daniel 1984a; Montgomery 1998; McGilvray 1982b, 2008). Such features regarding one's health are conceptualized by three qualities: *cuuti* (heating), *kulir* (cooling), and *kiranti* (eruptive). For ideal bodily health, one strives to maintain an equilibrium of these hot and cold qualities (Beck 1969; Babb 1975; Nichter 1987). It is quite common in Tamil communities to recognize certain foods, plants, and tress that can produce either a heating or cooling effect in the body (e.g., mangos are hot while coconut water is cold). Heat is more likely to cause illness because it is associated with changes that involve a mixing and transforming of bodily and non-bodily substances. Anger and heat are important qualities of some deities (e.g., Kali), and calendrical festivals provide a means to pacify and cool local deities. Skin problems, for example, on the head or face can be a sign of a humor imbalance due to an angry goddess' physical presence in an individual's body. In many Tamil populations, a healthy person is one who maintains an optimum balance between hot and cold substances. Certain Tamil-related rituals and festivals aim to bring about a balance of these qualities and substances.

Anthropological and ethnographic research illustrates how one's Tamil identity and health are deeply connected to supernatural forces, their relations (family and caste), and the places they inhabit (McGilvray 1982b; Mines 2005; Nabokov 2000; D. Somasundaram 1998, 2010, 2014). Through a variety of practices, people and places become mutually *palakkam* (or habituated), and qualities of a place and person changed to correspond to one another. Valentine Daniel's (1984a) ethnographic research demonstrates how substances and symbolic notions of connectiveness among Tamil-speaking people culturally formulate social and political rankings. He focuses on how these substances are transformed and established through social relationships and exist in states of equilibrium or disequilibrium with various degrees of fluidity. In analyzing

one's *ur* (home village), *vitu* (house), sexual partner, and sickness (*noy*) and health (*cuham*), he seeks "the substance" for which different substances develop. For example, though the Tamil notion of "*ur*" usually refers to someone's village, it is also attached to a person's household, caste and the soil of the land. Ur is person centric. It develops meaning through a person's background and shifting spatial orientation, where space is meaningful only in relation to places and times. Ur may also be described as a territory, a soil and substance that humans share and establish through different degrees of compatibility. This shared substance is largely formulated through notions of caste (*cati*). The soil of a person's ur conditions, in a fluid manner, one's habits or *kunam*, and vice versa. As Daniel (1984a, 101) described it, "This concern with compatibility results from the belief that ur is an entity composed of substance that can be exchanged and mixed with substance of human persons."

Tenuous Links Between Healers

Rooted in the legacy of westernized, colonial psychiatry, biomedical physicians in Batticaloa District often held unfavorable opinions of local healers due to evidence of physical abuse and high costs that negatively impacted their patients. In Chapter 3, I discuss the history of westernized psychiatric services in Sri Lanka during British colonial rule. A major pursuit to legitimatize the rule of the British empire was to demonstrate that their technology, science, and institutions were superior to local practices (Arnold 2004). Medicine and mental healthcare were no exception. The British had a different view of local medicine compared to the Dutch and Portuguese and tried to shield the population from local physicians, viewing them as performing quackery. These views were partly evidenced by Wambeek, the first superintendent of Borella asylum, and his insistence that those who sought traditional healing took too long to access and benefit from the westernized interventions of the asylum (Carpenter 1988). He suggested there would be more discharges from his hospital if patients had not sought out local indigenous treatments prior. Wambeek also suggested that family members often removed patients from the asylum before proper assessments, judgments, and treatments could be performed. These actions,

in turn, he suggested, caused patients to relapse into their former state. Most friends and family would have patients admitted in later or advance stages of the illness, only after native remedies and devil-dancing ceremonies had failed.

Prior to Dr. Ramesh's arrival and the major beginnings of mental health services in Batticaloa District in the late 1990s, residents usually went to traditional, religious, or spiritual healers to treat mental and emotional distress. Based on my ethnographic research, most people did not access professionalized ayurvedic, siddha, and unani services for mental and emotional problems in Batticaloa District. Clearly people accessed these services for pains, fevers, aches, or other forms of suffering that may not be identified as mental illness or emotional distress, and the ambiguities involved in such distinctions are important to recognize. I spoke to allopathic and professionalized indigenous practitioners who said clients with mental and emotional distress are not using these services in high numbers either now or in the recent past. When I asked Dr. Ramesh about working with ayurvedic and siddha doctors, he suggested people were not using these professionalized indigenous medicines to treat mental and emotional distress and this contributed to deficiencies in human resources in mental healthcare:

> No, clearly, that is one of the problems. You see, ayurveda, siddha doesn't actually deal with mental illness as such. So, that is a problem. Apparently, whatever was written got lost or something, people say various things. I don't know exactly. And also, even in like, ancient times, most of the mental illnesses were treated by spiritual leaders…So this is given over to the spiritual side quite early on.

Early knowledge and treatments of mental illness in early South Asian history suggest mental illness is rooted in supernatural phenomena, and spiritual leaders treated such aliments through mantras and various religious rituals. As previous South Asian scholars have noted, there are undefined boundaries between traditional healers and formalized indigenous medicine (ayurveda, siddha, and unani). Over the centuries, indigenous medicines have influenced treatment practices of traditional healers (*paricari*) and vice versa. Dr. Arthi—a medical officer from eastern Sri Lanka—started working with Dr. Ramesh in the early 2000s. She had intimate knowledge of both

professionalized ayurvedic/siddha and paricari doctors due to her family background and upbringing. When I asked about working with ayurvedic doctors, she shared:

> No, because my family are also ayurvedic doctors. My mother's father's family are paricari doctors. My mother's brothers are ayurvedic doctors. My mother's brother's son is an ayurvedic doctor. We have five generations of ayurvedic practice. But I don't think, I have never seen the mental health people coming. After a fever or that sort of thing…only [that] they are treating.

Thus, for residents in Batticaloa District, I also found it was common that treatments for mental and emotional problems were confined to biomedical/westernized healthcare, traditional doctors, and spiritual or religious healers.

When I informed mental health staff of my interest in different types of treatments for mental illness and distress outside of the hospital, they shared stories surrounding the relationship between Dr. Sivalingam's father and Dr. Ramesh. They noted many patients accessed Dr. Sivalingam's father's paricari services, and, if he thought their expressions demonstrated a "mind" (*mana*) "disease" (*nooy*), or madness (*paittiyam*), he would recognize his limitations and send them to the hospital. Dr. Ramesh always appreciated this, and often spoke highly of him. As Dr. Arthi described the situation:

> That is the traditional, traditional healer, paricari, pucari, that is the most available thing for our patients. First of all, with the abnormal behavior, they used to basically go to the pucari and paricari. After that only, they used to come, after finishing everything, money and everything, they used to come here…Yes, yes…the tradition, the mantras, *pey* [ghost]…Some paricari doctors, they give some medicine also…Oil massage, stand underneath a bucket of water…Usually, he [Dr. Sivalingam's father] treats first, then after that, he only say "go to Dr. Ramesh" (laughs). They used to come, "our paricari told us to come and see you." After that, sir [Dr. Ramesh] was very impressed, "ah, very good of him." … [*D: Is it helpful?*] No, no (laugh) they will come, after six months or three months, with very aggressive tendencies that they are unable to control. They tie their hands and legs, normally that is their habit.

As Dr. Arthi notes, mental health physicians had positive opinions regarding traditional healers only if they quickly referred patients to the mental health unit for treatment—i.e., the benefits of establishing a network with local healers and doctors to improve access to state-run mental health services. However, out of the 14 physicians I interviewed for this study, only one said he directly

referred his patients to indigenous doctors, although very rarely. As such, the colonial lineage of major social disconnections between allopathic doctors and traditional or indigenous doctors/healers still remains.

Much of the disenchantment with traditional healers comes from doctors' experiences with patients during consultations. Most patients sought out traditional and/or religious forms of healing prior to coming to the ward or clinic, leading doctors to sometimes encounter stories of abuse. Indeed, during observations of doctor consultations, I witnessed several patients who displayed bruises on their arms, torso, and legs that they attributed to paricaris. If such signs of abuse were apparent, doctors may write-up a report and give it to the police to investigate. One patient informant, Padmadevi, told me a story about being tied up on temple grounds and not given food or water. Her experiences are detailed in-depth in Chapter 6. As discussed later in the chapter, Marliya's health-seeking narrative illuminated financial and other abuses perpetuated by a bad paricari who suggested her household was being harmed by evil forces. When I asked Dr. Ramesh about establishing professional relationships and connections with traditional healers in the district, he expressed a shared sentiment of doubt among state-based mental health practitioners:

> I didn't really bother too much to make contact, or find out. Because, I mean, I have heard like, really bad stories about people being tied up, chained, and stuff like that…it was not possible for me to make any form of decent contact [sniffling] with them. I'm sure they all didn't do that. But, some of them did do that sort of thing. So I was not happy to make contact with them at that time…there was this, um, paricari…[patients] were chained in his bus garage. It was like, really, really horrible. And I had some patients brought from there. I think later on he kind of stopped practicing while mental health services developed. People stopped going to him.

Given that the history of mental and emotional healthcare in Sri Lanka, and broader South Asia, is often tied to external supernatural forces, traditional and religious healers exercise their authority over supernatural links and physical realms. Their authority is used to provide residents with protection (e.g., evil eye, black magic/curses, etc.) and to expel or manage supernatural

agents. Their aims correlate with and fit to local cultural rationales regarding abnormal behaviors, illnesses, and idioms of distress.

Prior to the availability of mental health services in the east, traditional, religious, and spiritual healers played a key role in treating people with mental and emotional distress, particularly for Tamil-speaking populations living in conditions of war. These practices still exist, for example, during temple festivals in eastern Sri Lanka, *teyvam* dancers go into a dancing trance-state after consistent rhythmic drumming and chanting by temple priests and assistants (Lawrence 1997a, 1998). The dances are spurred by supernatural forces entering the teyvam dancers' feet (Lawrence 2000). During temple festivals, it is not uncommon for these teyvam dancers to spend numerous hours dancing in a possessed state while providing oracle advice, whipping themselves, slowly walking on burning coals, and performing other such acts. These performances demonstrate supernatural agents are intruding them and causing abnormal behaviors.

Some traditional healers resort to whipping and other similar tactics to expel whatever supernatural agent(s) have entered patients' bodies. They may also chain them at a temple or healer site in order to control patients' movements and actions. For treating patients with mental illness or drug addictions (usually cannabis or ganja), Dr. Sivalingam aims to stop these people from acquiring more drugs, eating outside of the prescribed diet/medicines, or roaming the neighborhood. Though he would sometimes chain people to the healing center for treatment, I never observed him physically abuse (whipping, etc.) nor financially extort money from a patient.

Dr. Sivalingam: A Traditional Healer in Batticaloa District

Dr. Sivalingam's healing center is near a main road in Batticaloa District and sits at the back of his family's residence. The dirt driveway leading to his house is lined with a few medium sized trees and bushes. On one side of the driveway is a large garden of pots where he cultivates various herbs and plants to use in his healing activities. When I visited the healing center to observe, I would usually greet his mother and an assistant processing the herbs into liquids and

oils outside their house. After walking past the house, I could see the healing center slightly below on a lower slope. The center is a basic three-room building with a metal roof. Two of the rooms house patients who stay multiple days and the other room is used for his consultations. Just outside of this room is a small thatched roof and a wooden bench that serves as his waiting room during consultations. He receives approximately 30-40 patients per month from a variety of ethnic and religious backgrounds, though mostly Tamil Hindus and Muslims use his services. As he said, "All religions have come."

Dr. Sivalingam is in his thirties and is an eighth-generation paricari. His father went to India to study ayurveda medicine and began working as paricari in Sri Lanka in the early 1960s, and his uncle works as a paricari in a neighboring district. Dr. Sivalingam studied up to A-level and began working as a paricari full-time around 2012. Since the age of 10, he observed and learned his father's craft. Like his father, he uniquely specializes in treating mental illness. As Dr. Sivalingam describes, "We do it generation by generation, so we don't give up that profession. By being a paricari for mental illness, through this work, we are able to save the community." He mentioned that there are no other paricaris specializing in mental illness in the east but has met a lady paricari at an ayurveda center in Colombo and has heard of two paricaris in Jaffna. When I asked why other paricaris are not healing or curing mental illness, he said, "They do not have a license. It is difficult to get. They are doing the general medicine." However, based on my ethnographic research of patients utilizing state-run mental health services, residents access a variety of paricaris for mental and emotional distress throughout the district, regardless of certifications.

When entering Dr. Sivalingam's consultation room, there are no chairs and his floor is lined with woven plastic mats. Clients must remove their shoes and sit cross-legged, unless they are physically unable. I once saw him grunt and snap his fingers at a man because he was not sitting cross-legged while consulting with the doctor. Next to the doctor's spot is a small wooden stand with a stack of paper that he uses to write client's horoscope details; write mantras, or

charmed verses to give to patients to place somewhere; or wrap up powders to give to patients. The walls of his consultation room are lined with numerous glass and plastic bottles filled with mysterious dark liquids and white powders. He mentioned 18 different varieties of liquids he used to treat, or settle, patients. On the wall opposite to the door, there are three posters of gods and goddess behind a small table containing burning incense and a container for sacred ash.

Following techniques used in Hindu, ayurveda, and siddha medicine, as discussed earlier, Dr. Sivalingam's work involves observing the entire condition of the patient through pulse examination and other techniques. As he describes:

> First, I look at why the patient is standing in front of me. I identify the illness by observing the patient. Then I examine the pulse by keeping my finger like this. (shows with his fingers) I test if the patient is having an upset mind: whether it is substance abuse, or if the patient is having some other chemical changes in their body. So through my examination, I identify the problem.

If Dr. Sivalingam encounters someone dealing with mental and emotional problems, he will usually ask the patient to stay 10-15 days (or longer) at his healing center. For such cases, he said, family members were his main source of information about patients and were the primary decision makers regarding their health. As he describes "I am mostly asking questions to family members who brought them here…It is the relatives. I will examine the patient's mind and concentration, but the relatives or the parents, they will decide where to keep this patient, in the center or the hospital."

Similar to my observations of psychiatric services in the district, when clients are struggling with mental and emotional distress—as identified by his observations and pulse examination, Dr. Sivalingam seeks to stabilize them. As he describes:

> After testing the pulse, and observing if the patient is having illness, I ask the patient to bath with 100 water buckets over their head. After that, he will not feel the nerves and he will get really relaxed, feel refreshed. Afterwards, in the morning and evening, I give medicine to the patient and do the mantras for the duration of their stay here.

After treatments to calm clients' nerves and related distress, he proceeds to other methods (mantras, diet) that may heal them. However, during our interview, Dr. Sivalingam highlighted

his limitations in stabilizing patients when compared to allopathic/biomedical/psychiatric services. As he says:

> As I am not having injections or the tablets to make the patient sleep. Or, if the patent is aggressive due to the heroin or cannabis, only then do I send the patient to the hospital. I am able to treat him and get the patient cured, but it takes a long time. So in order to make him to have the good sleep, I will send the patients there.

Dr. Sivalingam lacks the technologies and expertise linked to state-run biomedicine and mental health services. Following his father's practice, he sends clients with severe emotional disruptions or sleeping problems to the hospital for injections or sleeping aids. Most of my observations of Dr. Sivalingam were of him treating minor forms of distress and other health issues (i.e., those not staying at the healing center). When I asked Dr. Sivalingam about patients that do not stay at the healing center, he said, "They are not the mental illness patient. They are the general illness patient. They have the fever or headache." He continued, "For minor problems, I don't keep them at the center. I am doing mantras and blessing the water. I ask the patient to come back in a week or two."

Most of the patients interviewed for this study who sought out traditional healing before, after, or during treatment from state-run mental health services did not stay at paricaris' healing centers. In consultations, I observed Dr. Sivalingam perform mantras with almost every patient. Mantras and mediating clients' connections with gods or goddesses are a crucial part of paricari healing activities. As he describes, "Things move with gods and mantras. While giving any liquids or herbs to a patient, I will praise the gods to heal the patient. That is the main aim for a paricari, to give medicines and do the mantras or some other pujas." Dr. Sivalingam uses the power of gods and "the voice" to move evil forces or spirits that have invaded clients. He conveyed this when I asked about the role of family members in consultations with patients experiencing mental and emotional distress:

> When I am doing the mantras, I am trying to take out the evil things inside the patients. So while doing the mantras, they will come out. So, for those things, I do not want to

> keep the relatives in this room. I get the relatives out of this room, only I keep the patient here to take out evil things inside of the patient.

With Muslim patients, he would even use verses from the Quran in his mantras. During his mantras, he sat cross-legged and said them in a rhythm of long inhalations, followed by a big push of air and mantra verses until his breath was exhausted, repeating this process. I would often see him perform mantra verses while he rubbed ash in-between the patient's eyes, blew ash through his fingers onto the client, or put ash in a container of water (various plastic bottles) for the patient to take with them and drink, anoint their skin, or pour around their home and land for protection.

Marliya: A Health-Seeking Case Study

Marliya started experiencing burning sensations (*eri*) all around her body (*udal*, or *udampu*). She is a middle-class Muslim woman in her thirties with two children and runs a small shop near her home (*veetu*). The burning sensations started when her husband was working at a hardware store in the Middle East. At the time of our interview, he was back in Sri Lanka and seeking employment locally. My research assistant and I first interviewed Marliya after her monthly clinic visit to Hospital B, and then a few hours later at her home. Her house sat along-side the only train tracks that ran through the district. It was surrounded by sheet metal and barbed-wire fencing that somewhat shielded her small courtyard area and entrance. As we walked through the sandy courtyard, I noticed a covered water well next to a small tree. I learned later that this well is symbolically connected to Marliya's burning sensations. She suggested that these sensations came after healing ceremonies were carried out by a Tamil man who claimed to be a traditional healer. A year or so earlier, she hired him for manual labor (*kooli velai*) and to dig a well on her property.

While carrying out his work, he suggested that someone had cursed Marliya and that evil (*paavam*) supernatural forces reside over her and her land. He asked her to buy some items and performed a few healing ceremonies at her home. He would usually bring a woman with him to

perform dances. She also walked around Marliya's property and found "charmed" items (nails, etc.) buried in front of her doorway—a token of proof that evil supernatural forces were disrupting her and her household. The man also gave her a charmed metal piece with a multicolored string for her to tie around her waist to provide protection (*kaappu*) from evil forces. This charmed item cost the extraordinary amount of 50,000 LKR, roughly $260 USD. A week later, when the charmed piece broke, she asked for another one. He told her it broke because she had done some bad behaviors and needed to buy another at the same price. In addition to paying ridiculously high prices for the healing ceremonies he performed (totaling more than 300,000 LKR, $1566 USD), at this point, she became suspicious and scared of the man. She decided to talk to her neighbors about what had happened. After she received a scolding for her actions, they told her this man had extorted money from people around town and did harmful supernatural things to them and their household.

Thereafter, the intense burning sensations started and lasted for six months. In some cases, she spent hours crying in agony and bathing in cool water for relief. This burning pain started to severely affect her ability to perform typical household duties and made her interact less with her children and other family members. She also harbored feelings of guilt because the Tamil man required her three sisters attend the healing ceremonies and they also developed similar burning sensations. Given her situation, a family member suggested she go to a paricari with a good reputation. After consulting with her mother and husband on the matter, they all agreed the best course of action was for her to seek out his treatment. The paricari gave her a charmed item to wear, cut lemons, and had her drink and bathe in water that had been blessed with ash and mantras for protection and mediating supernatural forces. For his services, she spent only around 5,000 LKR total. By doing such practices and meeting with the paricari, her burning sensations eventually went away. However, after two months, she still had problems with overthinking (*yoocinai*) and had an overall lack of sleep *(tuukkam illa*) and appetite (*paci illa*).

With Marliya's continued struggles with mental and emotional distress, she went to a private hospital and met a physician who then referred her to Dr. Pradeep. At a private hospital, Dr. Pradeep asked about the history of her illness and told her to come to Hospital B where she could be observed while she took new medications. Dr. Pradeep diagnosed her with depression and started her on a sleeping aid and antidepressants. When I asked about what Dr. Pradeep said to her mother, she remembered that "He told my mother, 'if she refuses the drug, you are the one who has to look after whether she is taking the drug or not. You have to tell her to take the drug and manage those things.'" She stayed in the ward for two days, but ultimately did not feel comfortable there. She did, however, continue her antidepressants and started accessing monthly mental health clinics at Hospital B. Since taking her medications, she has not had problems related to thoughtfulness and sleep. She describes her relief, "Now I can feel there is no mental illness on me. I can work freely, I can sleep, I can eat a lot or whatever I want."

Though these medical interventions provide quick relief for troublesome "symptoms," based on my ethnographic research, Marliya still struggled with sadness, numerous fears, and socioeconomic issues—problems mental health services are largely unequipped to handle. Clearly, Marliya's situation extend beyond symptoms, medical classifications, and treatments. Her health-seeking process demonstrates both individual and shared struggles, tensions, and contradictions in managing distress. Her experiences are echoed by other Tamil-speaking women whose husbands or family relations (son, etc.) worked abroad for long periods of time (usually the Middle East). Transnational labor was also associated with some clients' struggles to manage their households and life situations with their husbands gone for long periods of time. I discuss such commonalities within health-seeking narratives in Chapter 6.

Though Dr. Pradeep has excellent skills at counseling and helping patients and family members deal with socioeconomic problems, with the large patient loads, limited time with the doctor, and social environments of consultations, Marliya suggested she lacked privacy and opportunities to talk about her issues. As she describes, "In order to talk about private things with

the doctor, it has to be alone…Only the first time, I met with the doctor alone." She feels she would be able to talk to Dr. Pradeep more openly if other patients were not in the room. Besides close family members, Marliya did not have a lot of opportunities to talk about her problems, and she did not tell her friends about her distress because "they may look at me in a different way." In Chapter 5, I further discuss the pressures of limited human and material resources and bureaucratic routines in mental health services in Batticaloa that limit opportunities for patients to talk to and interact with physicians.

Though Muslims and Tamils share cultural practices related to traditional forms of healing in the east (McGilvray 2008), Marliya suggested that she was not fully comfortable with accessing traditional healers. Parcaris are usually associated with forms of Hindu medicine. Given the prevalence of transnational labor and the influence of Middle Eastern cultural ideas, dress, and habits regarding Islam and following the five pillars of Islam, some Muslim patients I interviewed suggested an uncomfortableness with seeking out paricaris because it was frowned upon by family members or neighbors, and because it at times contradicted their belief systems.

Marliya was having good connections with her husband's family prior to her initial paricari event, but her relationships were disrupted when she accessed traditional healers and paid high expenses for their services. Considerable money was also spent on her husband's flight(s) to come from the Middle East to help her. Along with not carrying out her duties as a wife and mother, and the high costs and negative opinions of traditional healers, Marliya stirred irritation among her husband's family members. As she describes, "At the time I was doing paricari healing, all the family members hated me. They didn't come to my house. After that, I told my family that I stopped going to the paricari. Now they come to my house. Now our relationship is good." Thus, for her and other Muslim patients living in the east, there were issues with seeking out paricari treatments due to financial strain as well as inconsistencies with their faith (*nampikai*).

Marliya's navigation through life situations, sociopolitical conditions, and cultural symbols of mental illness influenced her expressions of distress before, during, and after seeking state-run medical treatment. During her health-seeking process, she went through symbolic transitions and transformations (a death and rebirth) in which she and her family members learned to strategically navigate various healthcare providers in eastern Sri Lanka. With the free cost and cultural authority of allopathic services and practitioners, mental health services at Hospital B provided a socially-acceptable way for Marliya to manage and understand her idioms of distress—i.e., her "work of culture" or meaning-making acts regarding distress. Her health-seeking narrative highlights contradictions, deficiencies, and opportunities of plural forms of healthcare. Thus, with social disconnections between allopathic/biomedical and traditional caregivers, Marliya's health-seeking narrative shows how such social disconnections are negotiated by patients within their belief systems to formulate personalized strategies for managing their distress.

Conclusion

Though traditional authority has a certain amount of legitimacy among patients and the communities they live in—being tied to local belief systems, habits, and rituals, as suggested here, it is delegitimized in medical practice and in state-run mental health services. Thus, there are clearly sociocultural disconnections between different healthcare providers that are negotiated by patients in their health-seeking processes. Such discrepancies of authority between traditional and allopathic doctors are not just played out in public, but are also played out in an individual's negotiations with local pluralistic therapies. This research documents ways these contradictions and conflicts spur the development of meaningful personalized strategies for managing distress. I discuss contradictions in belief systems and socioeconomic struggles among patients accessing state-run mental health services in greater detail in Chapter 6.

In general, there are struggles in how traditional authority can be incorporated into state-run, bureaucratic institutions like mental health services. Given Sri Lanka's history of mental

healthcare and the fears or stigma surrounding it, residents in Batticaloa District have relied on traditional and religious healing long before and after state-based mental health services were implemented. Though Dr. Ramesh laid the groundwork for greater social exchanges between mental health staff and traditional healers, a key way to improve accessibility and establish strong social networks in communities prior to, during, and after Dr. Ramesh's tenure in Batticaloa District would have been greater inclusion of traditional healers. As Dr. Thilagam, a WHO employee who worked on improving mental health services in Sri Lanka's districts before and after the tsunami, suggests:

> It is better to take them also, because they do referrals and listen to people…the only difficulty is to get consent from the psychiatrist, right? They are not very keen on them because they said that these are not the proper way of treating people, right? …in Sri Lanka also, most of the people send money there. And then at the last minute, they come to the professional services, right? The misuse is also there, but in the future, I think it is better to incorporate them also, and train them on, you know, treating in a proper way or awareness to them; and if they identify somebody, they refer to services. And that's happening on a small scale…Because in Sri Lanka initially, the people won't come to the psychiatrist…they go to the traditional healers or the priest…to get advice. Later on they will come to the services. But, but now for the last 10 years, there are a lot of improvements in that regard…quicker than the past.

Further, following formal training on counseling and treatments—in an effort to avoid illegal, abusive practices and include traditional authority figures in planning—greater inclusion of traditional healers can provide a network of trusted caregivers that biomedical doctors feel comfortable referring to. These referral networks would also allow for psychiatrists to be in touch with local experts who could help monitor patients' progress and better link communities to mental health units in the district.

In early mental healthcare practice in South Asia, causes and treatments for mental illness were mostly tied to religious/supernatural activity. As such, mental and emotional health was determined by a person's metaphysical connection and link to spirits, kin, and place. These ideas and knowledge regarding supernatural links and an individual's health have a tremendous influence on healthcare decision-making, and, on how people ascribe meaning to their distress.

Based on my ethnographic research, residents in Batticaloa District did not utilize professionalized ayurvedic, siddha, and/or unani medicine to manage their mental and emotional distress. Much of this lack of connection may be due to the lack of professionally educated indigenous doctors who specialize in psychiatry (outside of the major ayurvedic hospitals in or near Colombo, Jaffna, and Kandy). Unlike in India, where it is more common to find professionally trained ayurvedic doctors who work in psychiatry (Halliburton 2009).

Given the importance of family to people's mental and emotional wellbeing, such relationships are crucial to coping, healing, and managing a person's distress. Along with a person's identity and role in the household/society, these relationships can also place intense expectations and stressors on people. Given people's connectedness to their family and the importance of maintaining family reputation and status in their respected communities, it is significant that people view mental illness and behavioral abnormalities as caused by familial inheritance–e.g., if the mother is suffering from mental illness, then her daughter and her daughter's offspring will get it. Part of the stigma and negative narratives surrounding state-run psychiatry or mental health services in Sri Lanka relate to the very process of seeking out psychiatric services can cause disruption or tarnish the reputation of the patient and/or family. Thus, residents living in Batticaloa District and elsewhere may utilize a wide variety of local spiritual, religious, and traditional forms of healing to manage mental and emotional distress.

The biomedical practitioners I spoke to said they found evidence of abuse (physically and financially) among their patients. Practices that swayed them from working with or referring to traditional healers. Though Dr. Ramesh appreciated when Dr. Sivalingam's father referred patients to him, he never established any kind of relationship or professional connection to him or others, which may have affected the accessibility of state-run mental health services, and the social networks between staff, patients, and community members. Referral networks and connections between mental health units and traditional healers in the district (or simply Dr. Sivalingam) are lacking both because of hierarchies and rational/legal features between different

forms of healthcare, and also because of negative opinions regarding traditional practices for managing mental illness that are seen as physically and financially abusive. Thus, if treatment gaps are going to improve in GMH programming, interventions should include traditional healers, but also be conscientious of hierarchies among different types of physicians, patients, and family members. Training and establishing networks with local healers will help to ensure people dealing with distress are not sent to abusive and unethical traditional healers. This development would also help foster bidirectional referral networks that would improve access and better support patients' psychosocial needs at the local level.

In the next chapter, I discuss the development of state-run mental health services since European colonialism and the introduction of westernized forms of psychiatric medicine. I examine the historical development of services in Chapter 3 and provide an analysis of psychiatric care and deficiencies in state-run services that correspond with a lack of human and material resources. Narratives of state-run mental healthcare in Sri Lanka tend to be associated with extreme, stereotyped forms of mental illness. Services have also largely been unavailable outside of Colombo until recently, and state-run mental healthcare has contributed to the stigmatization and marginalization of people managing forms of mental and emotional distress. Their distress has been exacerbated through a lack of social connections between psychiatrists and traditional healers, and limited state support. I argue that fostering social links between allopathic and traditional healers in mental healthcare would improve accessibility, lessen abuses among local traditional healers, and reduce the stigmatization of state-run mental health services.

Chapter 3: "The Angoda Model": A History of State-Based Mental Health Services in Sri Lanka

When a Sri Lankan references the subject of insanity, madness, or mental illness in conversation, it is common for them to evoke images, myths, and harsh sentiments surrounding Angoda hospital. I visited Angoda numerous times while living in Sri Lanka in the summer of 2013, and from 2016 to 2018. Located a few miles east of the capital city Colombo, it is hard not to notice the aged and robust walls surrounding the hospital grounds. At the entrance, usually stands the typical brown-uniformed security guard next to his booth. Past the guard and gate is a 50-meter road lined on each side with a wall and large trees. As three-wheelers honk and pass up and down the road, you can see colonial-style buildings, staff and patients working on manicured lawns and gardens, and groups of nurses giggling while walking to their next training session in pristine, white British-influenced uniforms. The buildings and grounds are testaments to the country's colonial past and history of mental healthcare that continues to influence social arrangements, procedures, and popular opinion of psychiatry and mental illness. Such environmental features are poignant reminders of custodial and institutionalized care—confinement practices that incarcerate, house, and treat people who are considered deviant, mad, or insane.

Alongside traditional and indigenous practices of mental and emotional healthcare that existed prior to European colonialism in South Asia, the history of colonial-era facilities and practices fuel legends, stories, and ambiguous knowledge about people deemed mentally ill. Built in 1926, Angoda hospital operated for three decades as the sole institution for psychiatry in the country and, thus, powerfully influenced forms, functions, and narratives of mental health services. During World War II, the Japanese mistakenly bombed parts of Angoda asylum accidently killing 10 and wounding 70. As buildings, walls, and other physical features at Angoda have decayed or been remodeled from a prison-like atmosphere over the years, so too have psychiatric practices for addressing psychosis and mental and emotional problems. However,

some foundational cultural rationales and "formulas of exclusion" still remain (Foucault 1965, 7). In this chapter, I review historical evidence in order to show how cultural knowledge and practices of mental healthcare at different historical periods include narratives containing both truths and falsities regarding mental health services on the island. These cultural ideas and practices contribute to problems associated with accessing state-run mental health resources and the marginalization of people managing mental and emotional distress.

I met and interviewed Dr. Ramesh at Angoda hospital on several occasions. During one of our interviews, he discussed the problems with Angoda, or what he called "the Angoda model." As Dr. Ramesh described:

> I think Angoda hospital has had a big part to play in that kind of marginalization, and the de-legitimations of the mentally ill. So, I mean, somebody being in Angoda hospital is a dirty secret that you have to hide until your grave. Because it automatically creates an image of people mad and running wild, naked, all that…when I say I work in Angoda, "Ah, so, there's no real fear for you? Nobody hits you?" "There's a lot of fun, right?" "Are people like dancing, singing?" I will say no it doesn't happen, and they don't believe me. So there is that kind of version of Angoda, which is in the popular image, in the popular belief system, and that's like, absolutely hell, right? …it's not the center of mental health services, but that's the image for the public.

Such myths or narratives of Angoda hospital and mental healthcare in general portray people who are suffering from mental illness or distress as insane in the most extreme, simplistic, and undifferentiated ways. As important therapies and cultural knowledge existed in South Asia prior to Western psychiatry, it is no wonder that patients fear utilizing psychiatric services in Batticaloa, and often seek out religious or traditional forms of healing for mental and emotional aliments.

Angoda provides a prime example of how cultural knowledge and practices of mental healthcare were developed out of ambiguity, a lack of understanding, and harsh colonial policies and governance. The hospital remains a key location for treating extreme psychiatric cases and training staff who come from various parts of the island. It provides a key representation of how psychiatry and other forms of mental healthcare have shifted with the introduction of new technologies, classifications, and policies, thereby influencing social arrangements of people

labeled mentally ill. Angoda serves as a prolific symbol shaping perceptions and misperceptions about mental illness, distress, and its treatment in Sri Lanka today. As such, Angoda represents what Ortner (1973, 1339) calls a "key symbol," specifically, what she calls a "summarizing symbol." A summarizing symbol refers to local expressions and representations of complex ideas and experiences in emotionally powerful, but undifferentiated ways. These symbols serve to catalyze emotions, aggregate complex ideas and experiences, provide a mode of orientation among actors, and can stand-in for the system as a whole. However, Angoda's history is intricate and dynamic and reflects various social and political economic changes that created both possibilities and barriers for health-seekers. Sri Lankans have weathered sometimes terrible and inadequately funded mental health services, overcrowded and poor sanitary conditions, and segregation from their communities. My ethnographic research suggests that such poor standards are still challenged and maintained within mental health services in eastern Sri Lanka.

The goal of this chapter is to examine key historical shifts in state resources, social organizations, and cultural knowledge and practices associated with mental health services, and the imposition of westernized psychiatry in Sri Lanka during and after European colonialism, now referred to as the "Angoda model." Here, I provide a macro-level historical analysis—i.e., global, regional, and national—to grasp ways past ideas and practices of mental healthcare were distributed and how these practices formed exclusionary cultural rationales. In this chapter, I argue there are distinctive cultural practices and ideas of mental and emotional distress during and following European colonialism. In later chapters, I demonstrate how cultural knowledge continues to influence both the accessibility and quality of services, as well as health-seeking strategies in eastern Sri Lanka. First, I briefly discuss state-run mental healthcare facilities prior to European colonialism. Second, I illuminate how cultural models of care for mental health during British colonialism and early western psychiatry were rooted in maintaining legal authority and containment tactics for communicable diseases such as leprosy, cholera, and smallpox. Such cultural rationales aimed to separate mentally ill individuals from society, communities, and

families, as well as dismiss local therapies as illegitimate. These cultural practices contributed to overcrowding, patient stagnation, and poor sanitary conditions. Historically rooted psychiatric practices inscribed a legacy of misconceptions that continue to marginalize people living with mental illness and distress. Third, I argue that after independence—with recommendations by mental health investigators or researchers, and the introduction of psychotropic drugs—there was a shift toward the decentralization of mental health services that pushed services toward individualized, biomedical treatments of mental illness and emotional distress. This shift is evidenced by the opening of outpatient and specialized clinics, and minor expansions of mental health services outside of Colombo in the 1960s. Major efforts to expand and decentralize mental health services also came in the wake of NGO and state responses to the 26-year civil war and the 2004 tsunami, which also saw greater focus on community-based programming.

In this chapter, I suggest that state-based westernized, psychiatric cultural knowledge and practices provide foundations and orientations for the way people identify, express, and manage mental and emotional distress. Historical shifts in cultural rationales regarding mental healthcare do not simply disappear; nor does one cultural rationale always trump another. Instead, it is important to understand the context in which westernized, psychiatric cultural knowledge and practices are implemented. For this project, I examine cultural rationales across different layers of sociopolitical complexity—i.e., local institutions, social interactions/communicative acts, and how individuals personalize cultural knowledge and ideas. I contend that medicalized practices in mental health services in Sri Lanka are pluralized and specialized through globalized political economic trends. To capture the plurality of state-run mental health services in studies of global mental health (GMH), it is crucial to carry out historical analyses and ethnographic research on westernized psychiatry and medicalized technologies that have influenced state-based and private forms of professionalized mental healthcare in Sri Lanka.

Sri Lanka and Precolonial Mental Healthcare

In the 2nd century BCE, spurred by Buddhist thought and kindred ethics (dharma), the Indian Emperor Asoka Maurya (274-236 BCE) made a famous decree to establish organizations for social medicine (Zimmer 1948). Alongside the spread of Buddhism, these organizations were extended as far south as the island of Sri Lanka. This created opportunities for the medical treatment of people and animals, as well as the growing or importing of herbs, roots, and fruits (Zimmer 1948). The earliest stone inscriptions of medical practice in Sri Lanka come from 247-207 BCE during King Devanampiyatissa's reign, a contemporary of Asoka (Uragoda 1987). Similarly, there are numerous south Indian inscriptions that refer to medical establishments attached to temples (Zimmer 1948; Basham 1998). For example, during the Cola dynasty (300 BCE-1279 CE), inscriptions were found in the inner sanctum of a temple dedicated to Lord Venkaeshwarara at Thirumukkadal, Tamil Nadu, that mention a hospital that cared for the mentally ill with 15 beds, a physician, nurses, and other staff (Somasundaram 2002).

An elemental text describing the early history of Sri Lanka is the Pali-based epic poem *Mahavamsa* (written 5th century CE). The Mahavamsa is a Buddhist text that tells the story of the founding father of the Sinhalese people, Vijaya, who was banished from northern India and arrived in Sri Lanka around 5th century BC (De Silva 2005). The Mahavamsa also describes the early kingdoms of Sri Lanka that created extensive and inventive irrigation systems (including inventing the valve pit) for agriculture productivity throughout the island. However, as power shifted between different kingdoms, such specialized systems became harder and harder to maintain and led to its eventual abandonment (De Silva 2005). Moreover, the Mahavamsa includes a small amount of evidence regarding hospitals established prior to European colonialism (Uragoda 1987). In 4th century CE, hospitals were founded by kings who appointed a physician to every 10 villages as well as other doctors to care for the army and their animals. King Buddhadasa (341-370 CE) of Anuradhapura was trained in medicine and authored a medical digest (Basham 1998).

In 5th century CE, hospitals within monasteries were established in Sri Lanka (Uragoda 1987). Given monks' literary and knowledge pursuits, it made them a logical choice to administer medical needs. During different reigns from 792-972 CE, major hospitals and other kinds of medical institutions were centrally located in the precolonial capital cities of Anuradhapura and Polonnaruwa (Uragoda 1987). There were also specialized hospitals that cared for the disabled, the blind, and obstetrical needs. However, according to Uragoda (1987), it was common practice at the time for ayurvedic physicians to visit patients in their homes. Another important figure in the development of healthcare was King Parakrama the Great (1164-1189 CE). He maintained a hospital with several hundred patients and provided a male and female servant to each of them. He also had granaries and dispensaries built to yield the crops necessary for a proper diet. Historical evidence of Sinhalese rulers and populations prior to westernized psychiatry show Buddhist doctrines were often used to explain and heal mental illness (Neki 1973).

Colonial Psychiatry and Containment Tactics

In 1505, the Portuguese made initial contact with Sri Lanka and marked the beginning point of European colonization. Portuguese, Dutch, and especially British policies and practices surrounding early mental healthcare were rooted in incarcerating and containing people deemed mentally ill. Here, I discuss cultural models of care for mental and emotional distress employed during European colonialism. Given that western psychiatry and colonial mental healthcare is rooted in legal frameworks and containment tactics—often linked to managing communicable diseases like leprosy, small pox, and cholera—individuals deemed mentally ill were isolated from their families and communities and were treated with reward and punishment systems aimed at managing behaviors, among other minimal treatments available at the time. Initial psychiatry in Sri Lanka required legal authority (district and provincial judges) to determine if someone was, "Deprived of their Understanding or Reason by an act of God and unable to govern themselves and estates." (De Alwis 2017, 24). Judges decided if such people were incarcerated (either in jails or mental hospitals) for breaking laws and disrupting sociocultural and economic norms

(Weerasundera 2012). As mentioned in the previous chapter, the British also discouraged people from seeking out traditional healers and indigenous medicines because such practitioners were considered quacks or illegitimate when compared to British medicine and its authority (Arnold 2004; Carpenter 1988; Harrison and Pati 2009; Kumar and Basu 2013; Uragoda 1987).

Local healers and indigenous medicine (ayurveda, siddha, and unani) treated forms of mental and emotional distress prior to European colonialism, yet the westernized psychiatry in Sri Lanka that largely began with British colonialism delegitimized these local practices. According to Carpenter (1988) and Uragoda (1987), the Dutch and Portuguese had very little influence on healthcare in Sri Lanka. They suggest this lack of influence is largely due to the underdevelopment of Dutch and Portuguese systems of medicine in comparison to the ayurveda, siddha, and unani medicine being practiced at the time of European contact in the 16th century. In addition to capturing land and establishing forts, the Portuguese built hospitals in Sri Lanka in places like Colombo, Mannar, Jaffna, and Galle, but these facilities were mainly for Portuguese soldiers and sailors.

A military agreement between the Dutch and Kandyan Kingdom effectively displaced the Portuguese from the island in 1640 (Peebles 2006). As a result, the Dutch controlled significant parts of the island, except for the Kandyan Kingdom territory. During Dutch colonial rule, hospitals were built, again, primarily for Dutch soldiers and sailors. However, these hospitals would provide the beginnings of key material and symbolic structures in the development of Sri Lanka's modern healthcare system. Specifically, Dutch facilities reinforced and provided the means to separation and distinction of the colonialist from the native, as well as governed and controlled who had access to health-related resources and knowledge. The Dutch system provided the foundations of healthcare tactics that separated people for the sake of managing smallpox, tuberculous, and other communicable diseases. In particular, the Dutch had an intense fear of leprosy when compared to the Portuguese and British (Uragoda 1987), this fear of contamination indirectly provided the beginning structures of westernized mental healthcare on the island. In

order to manage and contain people suffering from leprosy, the Dutch established a leprosy asylum at Hendala near Colombo in 1708 (Uragoda 1987). People with leprosy were incarcerated to prevent infection and barred from using public roads, mixing with the public, and selling food. As such, Hendala asylum provided the first colonial hospital to treat Sri Lankans, yet, was purely focused on leprosy cases and a few non-leprosy patients labeled as incurables (Uragoda 1987).

Assisted through operations with the East Indian Company, Britain fought for and expanded territory into South Asia. In 1796, after a raging war with Britain in the late 18th century, the Dutch transferred their colonial rule of Sri Lanka to the British. The British sought broader administrative control in Sri Lanka in comparison to the Portuguese and Dutch colonial powers. In 1819, after recommendations made by the Deputy Inspector General of Hospitals, Charles Farwell, to Robert Brownrigg, the British Governor of Ceylon, the second civil medical establishment was created at Pettah, Colombo to provide free healthcare to people considered poor and diseased. Medical services in Sri Lanka were also partially developed through charitable and missionary organizations that provided the only free treatments outside of Pettah hospital. In 1820, the American Board of Commissioners for Foreign Missions set up the first medically oriented mission in Jaffna. This lineage produced important figures like Dr. Samuel Fisk Green, who went on to establish the first westernized medical training program in Sri Lanka in 1846 (Uragoda 1987). Moreover, in 1831, the British introduced the "Friends-in-need Society," a system of voluntary charitable organizations sponsored by the Anglican church. A similar system already existed in Madras, India for 16 years. The organization provided free hospital care and dispensaries in such places as Colombo, Kandy, Trincomalee, Galle, Negombo, and Moratuwa. The establishment of free hospitals and dispensaries by the Friends-in-need Society and American missionaries helped spur the development of westernized medicine throughout Sri Lanka (Uragoda 1987).

In 1856, following a failed munity in India, the British took full and total administrative control of India and Sri Lanka—a period of rule known as the British Raj. This shift in

governance greatly influenced economic production and colonial healthcare systems in Sri Lanka. British prosperity there depended on the cultivation of coffee, tea, and rubber. It was important to keep a healthy workforce to maintain production of these agriculture goods and the establishments were developed through the colonial military regime (Uragoda 1987). In 1858, an independent Civil Medical Department was created, separating the medical department from military control, and marking a key turning point in the development of healthcare services in Sri Lanka. Developments spearheaded by Sir Williams Gregory aimed at training lesser-paid native physicians whose efforts focused on controlling and treating communicable diseases.

During the early years of British rule, most people viewed as mentally ill were put in jails or incarcerated. In 1839, Governor Mackenzie introduced "An Ordinance to Establish Lunatic Asylum," the first law of civil commitment in Sri Lanka to incarcerate mentally ill individuals in jails. With this legislation, provincial and district judges were given the authority to determine if someone was mentally ill through witness statements and personal inspections (De Alwis 2017). However, this authority was followed by complaints made by jail staff and prisoners, and the British colonial administration took steps to locate a facility to house people considered mentally ill (Mills 2006). Administrators moved those considered "mad" from jail or prison confinement to the leper asylum at Hendala. This hospital is the first known institution for the mentally ill (referred to as "lunatics") during the colonial era in Sri Lanka. Families and friends of those committed were required to pay for the expenses, a common practice at the time (Shorter 1997). The number of mentally ill people grew in the hospital, and in 1847, 58 patients were transferred from Hendala to a new "lunatic" asylum in Borella. The Borella facility had previously been a smallpox hospital and was located in a geographic area plagued with problems due to marshy land that contributed to the outbreak of diseases and death.

Mental Asylums and Custodial Tactics

In its early years, Borella asylum recorded a high mortality rate among patients: 21 out of 99 patients died (Carpenter 1988, 14). Patients lived in dormitories built to house eight, while

violent patients were individually housed in a series of small rooms. In 1851, Wambeek became the first superintendent to take charge of the asylum. Noting an increase in the number of patients, Wambeek stated:

> …the extremely crowded state of the wards, particularly in the Male division of the Asylum, during these periods, it was deemed essentially necessary to bring the matter to the notice of the Government through the Principle Civil Medical Officer, and reluctantly to recommend, that admissions should be regulated by the number of vacancies occurring by Discharge and Deaths. The consequence of this measure was that Jails in the Island became filled with "lunatics", and it was not till 1856, when the Asylum was enlarged by the addition of buildings to it, that these poor sufferers were transferred thither from the different prison. Hence the large number of admissions in 1856 and 1857. (Wambeek 1866 as quoted in Carpenter 1988, 5)

In 1856, the number of patients there increased to 103. Of course, this count does not accurately reflect those needing services as many mentally ill people remained incarcerated in jails. Carpenter (1988) suggests this rise in admissions was largely due to a legal problem: The Lunacy Ordinance of 1839 required the incarceration of all persons identified as mentally ill for observation, treatment, or evaluation. In 1864, the Principle Civil Medical Officer recommended that a house be rented near the asylum as a place to hold those with mild cases of mental illness, it was initially called a "hospital of observation," and later became "house of observation" (HO) (Carpenter 1988, 45). These HOs operated as in-betweens for medical and legal realms that did not always work in accordance with one another. In 1894, as the number of suspected mentally ill cases grew, HOs existed in Kandy, Colombo, Galle, and Jaffna. By 1914, HOs were phased out due to problems of management and paperwork.

In 1865, an extension was built onto the asylum and briefly eased overcrowding. However, Wambeek's further requests for greater assistance and facilities were ignored (Carpenter 1988). Though conditions were very poor, it was sometimes better for mentally ill patients in the asylum as compared to outside. Part of this was due to a diet plan in 1858 that provided food and clothing for all the patients; however, there were differences of clothing and bedding between the Burgher patients and the native patients (Carpenter 1988).

In India, Sri Lanka, and elsewhere, the main concern of mental hospitals and westernized treatment practices during the 19th century was to sever patients from society and correct their behaviors within institutions—referred to as morality or moral therapy (Das 2015; Ernst 1999, 2009, 2010; Jain 2011; Pinto 2018; Shorter 1997). Methods such as consolidation, purification, ablution, and regulation of movement were utilized. Although treatment or therapeutic options for patients were limited at the time, yet humane practices were occasioned through Wambeek's order for staff to remove the patients' restraints and clean them. There was a four- to five-year period where they did not use waistcoats. Bleeding was thought to ease lunacy, but Wambeek did not see any benefits when treating patients (Carpenter 1988). He preferred the use of a tonic treatment plan, cold baths, opium, cannabis Indica, exercise, and general amusement, and he measured effectiveness by gauging how patients managed extreme emotions or manic behaviors.

Wambeek also experimented with occupational therapies to provide employment for patients. An established treatment in Britain at the time, Wambeek was cognizant of the practice as a treatment tool rather than exclusively as a free form of labor. It was not mandatory to carry out this work, but he stressed the problems of inactivity in regard to mental wellbeing. An "Industrial Work" program was established and provided patients with travel money and the ability to purchase various items (e.g., recreation equipment and faculties, daily rations of betel nut, etc.) that were otherwise unavailable due the asylum's lack of resources (Carpenter 1988). For these purposes, Wambeek purchased a loom, spinning machine, and arrow root machine. Under staff supervision, patients loomed, harvested arrow root, practiced carpentry, and also cleaned and maintained the grounds of the asylum. There was also recreational therapy in which patients read books (if they were literate in English) and participated in playing cards and other games. In 1907, control of the Industrial Fund shifted away from the hospital to the colonial government. The program soon fell to the wayside in favor of other pressing problems within the institution. Only after independence, more than a half a century later, were these programs further developed (Carpenter 1988).

In 1860, a board of visitors published a report about the asylum (Carpenter 1988). The report confirmed Wambeek's accounts that the biggest problems regarding Borella asylum were overcrowding and a lack of accommodations. However, they noted marked improvements at Borella, suggesting patients looked healthy, and praising Mr. Wambeek's work as "judicious," "sound," and "moral" (Carpenter 1988, 11). The visitors were particularly encouraged by the occupation programs established by Wambeek. They recommended permanent facilities be built in order to support these activities, and to allow spaces for patients to gather for amusement and to divert their thoughts. In 1861, Wambeek was transferred from Borella asylum to another position in Jaffna. In the late 1870s, Dr. Kriekenbeek was put in charge of Borella asylum. He immediately requested for new facilities to be built and was prolific even though he severed Borella asylum for one year prior to his death.

During his tenure, Dr. Kriekenbeek documented overcrowding and poor sanitary conditions that made patients susceptible disease (Carpenter 1988). However, the colonial government was reluctant to accommodate these requests, leading the asylum into a further state of despair. When Dr. Kriekenbeek assumed control of Borella asylum in 1877, little or no attempt was used to classify or separate patients in relation to their disease or behavior. Besides secluding violent or out-of-control patients from the rest of the ward population, no lasting work had been done to classify patients based on their behaviors, symptoms, or personalities. He began to classify and access different forms of mental illnesses. He separated the "quiet and harmless cases" from the "excitable and violent, and the clean from those who are dirty habits" (Carpenter 1988, 21). In general, separation of patients was mostly due to cleanliness or dirty "habits," and patients would be rewarded or punished based on this factor. He also used behavioral modification techniques, in which patients with "dirty habits" were moved apart from the general population to different sections of the asylum. A reward and punishment system were also established for patients who kept "cleaner habits." His overall goal for treatment was to lessen the

number of patients exhibiting “dirty” habits in the asylum. However, there is no evidence that this program continued.

British economic activities in Sri Lanka, and South Asia, during the 19th century brought indentured servants from India to work on Sri Lanka’s tea plantations and other important industries. With increased movement of goods, resources, and people, Sri Lanka—being an island country—was exposed to increased outbreaks of communicable diseases, including non-endemic infections like cholera, which was introduced by the British and had a higher mortality rate than smallpox. With the colonial government failing to act, in 1865, there was an outbreak of cholera, which killed 13 patients out of 27 reported cases. These epidemics were considered as more pressing health problems than mental illness, and the government moved funds and resources away from the asylum.

Borella asylum’s final years were led by two other key superintendents: Dr. Plaxton and Dr. Vanderstraaten (who served temporarily until Dr. Plaxton arrived from England). Each administrator had their own unique style and ways for treating and understanding mental illness. While Dr. Kriekenbeek focused his attention on the classification of patients, Dr. Vanderstraaten improved the environmental conditions of the dated Borella asylum, and Dr. Plaxton brought new skills and ideas for planning and developing the eventual new asylum at Cinnamon Gardens.

In addition to repairing Borella’s environment, Dr. Vanderstraaten also focused on fostering the amusement of patients. He had, “the wards decorated and ornamented in the style suited to native tastes” (Carpenter 1988, 22). To take advantage of every opportunity to provide amusement for patients, he had an aquarium built and took patients on trips to places like the national museum. Interestingly, when Dr. Ramesh started services in Batticaloa District, the mental health unit had a fish tank that he liked to sit next to and feed the fish while he carried out his consultation with patients.

Cinnamon Garden Asylum

In 1871, although there were only 250 people in Borella, the census reported there were no less than 3,319 "insane" people on the island (Carpenter 1988, 23). Thus, colonial administrators suggested that a larger asylum should be built to manage fluctuations in the economy. In 1876, the PCMO, Dr. Kinsey, reported that a new mental asylum site would be erected (Carpenter 1988). The new asylum took considerable time to build and yet was viewed as insufficient in size in order to manage an increase of patients. Even so, in 1888, all patients had been moved into the new asylum at Cinnamon Gardens under the supervision of Dr. Plaxton.

By 1908, the new institution was in a terrible state with a high death rate, a low recovery-rate, and several outbreaks of epidemic diseases. Given the lack of response on part of the colonial government, Dr. Spence, the successive Medical Superintendent of the asylum after Dr. Plaxton, expressed his frustrations in numerous administrative reports. He stated 750 people were being accommodated in a building permitted to house only 400 people (Carpenter 1988, 28). He utilized figures about discharge rates and patient population sizes from Britain and its colonies (Jamaica, Singapore, India, etc.) to make arguments to procure funding for the asylum. There were also difficulties with maintaining and cleaning the facilities and grounds. For example, the water supply at the asylum was inadequate, making it difficult to maintain cleanliness. Given these issues, Dr. Spence said, "it is a matter for surprise and thankfulness that the results as regards the general health of the institution were not worse." (Administrative Report 1910; as quoted in Carpenter 1988, 32).

Angoda Hospital and Mapother Report

In 1926, eight years after construction began, Angoda mental asylum opened and provided 1,728 beds. By 1927, the hospital was near capacity, with an average population of 1,716 patients (Carpenter 1988, 35). Angoda operated at a high capacity while the "noisy" ward, an area for patients deemed violent or out-of-control, was being built. A lack of state support may have been due to the dramatic rise of Malaria cases and deaths in the country. These figures

reached staggering proportions in the Malaria epidemic of 1934-1935, in which 80,000 people died, about 1% of total population (Uragoda 1987, 228). However, Silva (2009) argues that the epidemic and state response to the epidemic helped paved the way for welfare programs and socialized medicine, which would eventually make state-run healthcare (mostly) free in Sri Lanka. There was a considerable rise in population following socialist welfare policy changes, likely connected to the overcrowding in Angoda in subsequent years.

In 1937, the Medical Superintendent of Maudsley Hospital in London, Dr. Edward Mapother, came from England to do an analysis on the conditions of Angoda asylum and provided recommendations to the British government (Mills and Jain 2007). He conducted similar observations in India after visiting Sri Lanka. This study would be called the Mapother Report. His report is important because it gave recommendations and standards that influenced mental healthcare after Sri Lanka's independence. It also provides an independent observation of the state of mental healthcare in Sri Lanka and India in the 1930s. His 1938 report outlined the poor state of Angoda hospital with overcrowding, poor sanitary conditions, and temporary, unsafe buildings housing patients. Most patients slept on mats and were tightly packed into various spaces throughout the wards. "Noisy" ward patients stayed in windowless rooms that were rarely cleaned or opened. He described terrible noises that came from this ward at night and could not imagine these conditions for patients suffering from bodily illnesses. The women's ward was cleaner, which he suspected was due to a matron who enforced order and cleanliness (unlike her male counterpart). Mapother suggested that such displays of enforcement were probably due to the matron's training in England. Moreover, the men's ward was significantly overcrowded compared to the women's ward.

He also found that there was a total absence of occupation. He described people sitting and doing nothing, occasionally giggling without reason. He states, "no reconditioning of the present Lunatic Asylum at Angoda will ever render it suitable accommodation for any but a chronic type of insane." (Mapother 1938; as quoted in Carpenter 1988, 40). For Sri Lanka, he

suggested major problems within asylums were due to: 1) a lack of space and beds for patients, 2) shortage of provisions given the demands, and 3) low budget and quality of provisions. “Those in authority in the East,” Mapother wrote, “have not yet reached a modern standpoint with regards to the relative importance of mental disorder and its treatment” (Mapother 1938; as quoted in Carpenter 1988, 40). Interestingly, India had a lower ratio of beds to population when compared to Sri Lanka, but he reports that they did not have a serious problem with overcrowding. He suggested that overcrowding in Angoda was greater than any mental hospital he observed in India. Such overcrowding and poor sanitary conditions spurred outbreaks of tuberculosis and dysentery that killed numerous patients (Carpenter 1988). Mapother also reported that there was a low ratio of medical officers providing care for patients.

With overcrowding and other problems at Angoda, the asylum as a place with curative treatments for mental disorders was non-existent. Mapother made recommendations to: 1) revise the existing lunacy ordinance laws, 2) decentralize from one main hospital to Kandy and other regions of the island, 3) provide recreation and occupational therapy, and 4) develop new facilities that deliver such services as short-term treatment, a house of observation, and a neuropsychiatric clinic (Carpenter 1988). Following the report, a neuropsychiatric clinic was established in Colombo General Hospital in 1943 (with a 25-bed unit) and was the first time a psychiatric unit operated separately from the country’s mental hospital. Mapother felt that a chief problem was a lack of training and specialization and suggested the need for a special service of medical officers devoted to psychiatry. He also suggested that Ceylon Lunacy Ordinance in the 1930s had changed little since the 1800s. Lunacy laws in Britain changed considerably in the 1890s and would serve as a model for the Mental Treatment Act of 1930—which dealt with mental illness as a crime versus as an illness. However, Mapother argued that judicial authority still came first, and only secondarily was medical evidence sought. In his opinion, to modernize, Sri Lanka would require significant revisions to mental illness laws (“lunacy” laws) by establishing a demarcation of how criminals and mentally ill people were treated.

Liberalizing of Services: Decentralization, Voluntary Admissions, and Psychopharmaceuticals

In 1948, when British colonial rule ended in Sri Lanka, a site was selected for a new mental hospital. Though it was recommended that Sri Lanka decentralize its mental health services in the Mapother report, the government selected Mulleriyawa, which is only two miles from Angoda. According to Carpenter (1988), this decision was largely based on the limited availability of trained personnel outside of Colombo. Finished in 1959, Mulleriyawa hospital moved away from the prison-like atmosphere and buildings at Angoda and attempted to modernize mental health treatment in Sri Lanka. The site even offered treatment and separate wards to juveniles and children in 1960. At Angoda in 1950, a separate medical ward was established for patients that were physically ill. A library was also created, as well as an occupation program like the Industrial Works department established by Wambeek a century earlier.

During the 1950s, numerous Sri Lankans were sent to England to be trained as mental healthcare providers. They trained as occupational therapists, social workers, nurses, and medical officers. In 1956, the first trainees returned to Sri Lanka and had a major effect on Angoda hospital and the decentralization of psychiatric services. The expansion and decentralization of mental healthcare started with the beginning of voluntary, outpatient clinics at Angoda in 1950. The treatment system was reorganized at Angoda into three units, headed by three psychiatrists, to ensure patients received more time with the psychiatrist. By 1957, the number of nurses (from 2 in 1950, to 12 in 1952) and psychiatrists per patient increased, allowing for three units to expand to 10 units, each responsible for outpatient clinics and staffed by a psychiatrist and assistant medical officers (Carpenter 1988, 55). With stigma surrounding mental illness slightly fading, some people felt comfortable seeking out voluntary treatment. Outpatient services were eventually expanded to Colombo General Hospital. There they developed a childhood guidance program that provided psychotherapy, play therapy, speech therapy, advice to patients and teachers, intelligence testing, and vocational guidance. Social workers at the hospitals formed the

group, “Voluntary Association for the Care of Psychiatric Patients,” in June 1957. In this group, patients would discuss their problems, meet with their family members and employers, as well as attempt to re-socialize with friends and community members. As a result, one administrative report in 1957 claimed that, “A great change has taken place in the attitude of the public in Ceylon towards mental diseases. These diseases have been brought out of the darkness, when mental and emotional problems are now freely discussed. The stigma of mental sickness is slowly fading and patients are beginning to go to voluntary treatment” (as quoted in Carpenter 1988, 52).

Besides the use of paraldehyde, bromide, and opium, prior to 1950s and 1960s, there were few pharmacological treatments available for treatment of mental and emotional problems (Shorter 1997). The introduction of psychotropic drugs revolutionized care and provided the groundwork for the further decentralization of services to hospitals outside of Colombo, with in-patient facilities opening in Galle, Kandy, and Jaffna in 1965 (Carpenter 1988). Facing continual overcrowding issues, a third hospital was opened in Pelawatte, mainly for housing convalescent patients in work therapy programs. This hospital became even more active after a psychiatrist was posted there in 1961. In 1962, it was turned into a village settlement for the chronically mentally ill that would eventually be assimilated back into the general community. However, it was later discontinued in 1964. In 1962, Nagoda became first mental hospital to be built 30 miles outside of Colombo. By 1965, patient turn-over in the hospital greatly increased, largely due to the introduction of new psychotropic medicines. With attitudes towards the mentally ill changing, clinics were established at all mental hospitals to encourage outpatient care.

A key legislative change regarding mental healthcare came with the passing of the Mental Disease Act of 1956. The Act legislatively introduced temporary, voluntary, and emergency admission to mental hospitals (De Alwis 2017). Such changes incorporated aspects of the British Mental Treatment Act of 1930. As such, the Act was meant to bring Sri Lanka’s mental health policies more in line with other countries with more liberalized laws. Patients could be admitted to a hospital with the recommendation of two medical practitioners without having to

go to a district court—a previous requirement of past ordinances and amendments. This Act led to a major increase in temporary and voluntary patients (from 124 in 1956, to 1,466 patients the following year) (Carpenter 1988, 55). This was a significant shift, as since the early 1800s, all patient admissions and discharges were handled by the courts.

In 1966, Dr. Wickremesinghe, the Deputy Director of Health Services, developed a commission to study the mental health system in Sri Lanka (Carpenter 1988). With the assistance of a World Health Organization (WHO) consultant, the commission developed a report that recommended further decentralization of mental health services. The commission suggested that psychiatric facilities be opened in Galle, Kandy, Jaffna, Rathnapura, and Kalutara. They also recommended that efforts should be made to: 1) appoint an individual responsible for mental healthcare reorganization, 2) separate forensic psychiatric patients from the general patient population, 3) change Angoda mental hospital to an open-door principle (i.e., easier for the general public to access), 4) organize community-based mental health programs, and 5) revise the Mental Disease Ordinance (Carpenter 1988). They suggested there was poor maintenance of medical records and that these records did not conform to the English standards. They noted the Mapother report in 1938 that Angoda mental hospital had an 82% overcrowding rate (3,000 patients for intended size of 1,830), and at the time of the Wickremesinghe Committee it was 109% (5,026 patients intended for 2,262) (Carpenter 1988, 57). Along with overcrowding, there was a lack of response by the government's Public Work Department (who manages water and sewage issues), that left a large percentage of defective latrines, drainage systems, pipes, and water taps. They also found the library program was mostly unavailable to women at the hospital.

The committee also addressed problems with staff shortages, due largely to a lack of available in-country training. With only 20 psychiatrists in Sri Lanka in 1964, it was recommended that 36 were needed for the immediate future (Carpenter 1988, 58). All psychiatrists had been trained abroad, and there were no facilities for psychiatric education in Sri Lanka at that time. As previously noted, psychiatrists labored without proper facilities. Medical

officers made the most significant complaints saying that there was a lack of staff recruitment and training, and long hours of duty. The committee recommended there be at least one psychologist for each psychiatric team. This recommendation is important because there has always been an extremely low number of psychologists in the country, and this contributes to problems of psychosocial support in current mental health services. They also said nurses were overworked and heavily needed, which contributed to the delays in decentralizing services (one nurse for every 40 patients) (Carpenter 1988, 58). For example, at the time of the report, none of the seven trained nurses had been moved to Mulleriyawa after its opening. Of the eight psychiatric social work positions available, only three were filled. Much of this was attributed to their low salary in comparison to time for training: one-year of work in the hospitals and three years of training in London were required for social workers. For comparison, they were paid less than a teacher who completed only a one-year training course.

The committee also recommended the integration of public health and mental health, pushing for public health officers to undertake activities such as early detection and follow-up services for discharged mental health patients. They also called for a community mental health system throughout Sri Lanka, increased training of public health personnel in mental hygiene, and the general integration of mental health work with public health work (headed by a psychiatrist) (Carpenter 1988). As part of decentralization, the committee wanted to implement peripheral psychiatric units in general hospitals.

A department of psychiatry within the Medical Faculty at the University of Colombo was created in 1968, and the following year, Peradeniya University at Kandy followed suit. The University of Colombo's department established a community clinic in Kotte as part of an epidemiological research project from 1973 to 1976 with assistance from the WHO (Carpenter 1988). It attempted to relocate long-term patients to their homes in Sri Lanka. During its year of operation in 1976, 109 patients were returned (Carpenter 1988, 63). However, most families were not found, and the program ended due to a lack of WHO funding. Departments of psychiatry were

opened in Jaffna and Galle in 1982. Post graduate training for psychiatrists to obtain a Medical Doctorate (MD) in Sri Lanka began in 1981 with a five-year training program and the establishment of the Post Graduate Institute of Medicine. Further, the National Council for Mental Health, a non-government organization, established a community rehabilitation program near Colombo in 1983.

Though most of the committee's recommendations were not implemented in the years that followed, there were some key changes made to psychiatric care and training. There was an overall increase in establishing peripheral units at general hospitals, was well as in-country training of nurses, occupational therapists, and social workers. In 1966, we see the beginnings of community-based care and decentralization, which allowed some psychiatric patients and their families the opportunity to avoid traveling long distances for hospitalization. This decentralization also allowed patients to maintain contact with family and friends, which was often minimal or non-existent for patients coming from various places on the island. However, these programs were never developed due to a lack of funding, training, mental health workers (psychiatrist, etc.) and organization by implementing parties (Bennett 1971). At the time of the Wickremesinghe report, mental health services only accounted for 4% of the annual health budget (Carpenter 1988, 66). By 1979, only 10% of the recommendations were implemented. Professional activities in the 1960s and 1970s included the Ceylon College of Psychiatrists, later changed to the Mental Health Association, an advocacy group active from 1955-1970 (Carpenter 1988). But, in the 1970s, there was a significant "brain drain." Numerous doctors and other educated professionals left the island, limiting the decentralization of services and the implementation of community-based programs (Chandrasena 1979).

Shifts in Mental Health Policy: The Civil War and 2004 Tsunami

With already sparse human resources in mental health services in Sri Lanka, there was even more migration of mental health staff to other countries with the outbreak of civil war in 1983, particularly in the north and east. The few mental health facilities that existed outside of

major cities were damaged during the civil war and supplies and transportation were disrupted. In 2002, only two districts in the north and east had available acute inpatient facilities (WHO 2014). A major decentralization of mental health services came after the 2004 tsunami with the 2005 Mental Health Action Plan, as well as "proposed" changes to mental health policy (Fernando and Weerackody 2009). After catastrophic destruction caused by the tsunami, a Presidential Task Force was set-up to bolster mental health services and provide relief to tsunami victims. Moreover, a large amount of international donations and support from NGOs provided a surge of resources and funds to address mental healthcare needs. Though NGOs provided human resources and training, they mostly provided funds to build mental health infrastructure and facilities, as well as develop community-based services (Mahoney et al. 2006; WHO 2013). Such aid relief attempted to address mental wellbeing and psychosocial issues rather than purely a "psychiatric response" (WHO 2014). Following the tsunami and meetings between key stakeholders, there was significant momentum to develop mental health services. A plan came together through the development of a National Mental Health Policy and Action Plan from 2005-2015. The Plan aimed to strengthen technical development, infrastructures, human resources, community participation and empowerment, and research and ethics in mental health services (Gambheera 2016; Jenkins et al. 2012; Minas, Mendis and Hall 2017).

With governmental and non-governmental support, 16 intermediate stay rehabilitation units were established, as compared to five units prior to the tsunami (WHO 2013). Moreover, 21 out of 26 health districts had acute inpatient units, as comparted to 10 out of 26 before tsunami-related responses (WHO 2013). Given a lack of human resources in mental health service, there was a big push to train doctors, nurses, and community-based workers. In the early 2000s, a three-month medical officer of mental health program was established in order to fill the void of mental health staff. Prior to the tsunami, there were 35 medical officers of mental health, now there are 131 (WHO 2014, 34). A one-year post-graduate diploma in psychiatry for medical officers (MO) was also established after the tsunami. There are now 60 diploma holders in 25

health districts (WHO 2014, 34). As part of developing mental health services, training in community psychiatric nursing was created; there are now 46 community psychiatric nurses. Moreover, there was training of mental health lay workers, known as Community Support Officers (CSO), who would identify early signs of mental illness and psychosocial problems in rural areas, provide regular support at the community level, help people gain access to compensation and living allowances, and assist with treatment compliance among people managing mental illnesses (WHO 2014). It is estimated that more than 500 CSOs were trained (WHO 2014, 33). Given these dramatic changes since the early 2000s, within global mental health organizations and their actors, Sri Lanka is often viewed as a successful model for "building back better" mental health services following the 2004 tsunami and decades of civil war (WHO 2013).

Conclusion

Angoda hospital is a key symbol that serves to condense Sri Lankan sentiments and ideas regarding mental illness and mental healthcare into negative stereotypes and generalizations. Dr. Ramesh's notion of "the Angoda model" helped convey the complex history and numerous setbacks regarding state-run mental health services in Sri Lanka since colonialism. Prior to major changes after 2000, the Angoda model represented a negative sentiment through a homogenous lens regarding state-run psychiatric services. Services characterized by a lack of state resources and the inhumane practices of early westernized psychiatry contributed to the stigmatization of mental healthcare and people living with mental illness. Dr. George describes how Dr. Ramesh worked against the Angoda model:

> …But, here, I was working with Dr. Ramesh, which is mainly community work, rather than the ward works. And the, Angoda is like, you know, it is like a prison, when I was studying there. Because earlier we had a training for MO mental health training in Angoda, so it was like a prison area. But somewhat improved…So, afterwards, um, I tried to practice like, Dr. Ramesh methods like community works; more than the ward works (laugh)….The other thing is like holistic approach.

Dr. Pradeep echoed a similar idea regarding negative features of the Angoda model of care:

> …I have my experience of Angoda during my training, that is totally institutional, only for the chronic patients: schizophrenia, bipolar…And totally their practice is medicine. Not any other family support, social contacts, or counseling, no psychosocial approach. They never accepted the psychologist or counselor…This is in 2006, later part…all are the chronic patients. It is very seldom you would see a new patients…They are only thinking about symptoms, symptom control, then medicine, and taking the medicines, those ECT; this is a regular practice…[But] the access for the psychosocial part…practices are different from when I started my work with Dr. Daya Somasundaram. He was totally with the community, and his main practice, especially with the traditional and other method for the healing of war-related and other kind of stress, huh? And even in the hospital he managed patients, yeah, medicine to stabilize the patient…

Historical narratives and psychiatric practices play an important part in mental health services today among staff, the public, and Dr. Ramesh's approach to setting up mental health services in the east.

As this chapter outlined, origins of psychiatry and psychiatric practice in Sri Lanka are tied to legal-bureaucratic authority and rationales, as well as to strategies and techniques aimed at lessening communicable diseases (important to the British in order to maintain productivity in the region). Michel Foucault (1965) in *Madness and Civilization* describes similar developments between leprosy and mental illness happening in European societies:

> For that act of drawing a line around a space of confinement, of giving it a special power of segregation and assigning madness a new land, however coherent and willful it may appear at first glance, is anything but simple. This complex unity brings together a new sensibility to poverty and the duty to relieve it, new forms of reaction to the economic problems of unemployment and idleness, a new work ethic, and the dream of a city where moral obligations go hand in hand with civic duties, all held together by the authoritarian forms of constraints. (Foucault 1965, 54)

In Sri Lanka, such rationales placed people suffering from mental illness in jails, asylums, or temporary housing to separate them from communities while providing mostly moral therapy and few pharmacological treatments. According to law, judges had authority to decide if a person was mentally ill or not. It was only later that this law was amended, so medical practitioners had authority over whether a person should be committed to the asylum. Mental health leaders and directors had difficult times acquiring resources and funding from both the colonial government and state, leading to overcrowding and sanitation issues. Such historical trends demonstrate the

lack of concern by the state toward people managing mental illness. In the 1950s and 1960s, we began to see efforts to decentralize (increased peripheral units) and specialize (different clinics, multidisciplinary units, etc.) services in Sri Lanka. Much of this shift is due to the first developments of psychotropic drugs in 1946. With shifting attitudes towards mental illness and its treatment, voluntary treatment was instituted, along with changes to Sri Lanka's mental illness policies and laws (e.g., Mental Disease Act of 1956). In 1966, the Wickremesinghe commission provided an assessment of and recommendations for mental health services in Sri Lanka; in particular, the report highlighted major issues such as low human resources and a lack of integration of public health and community-based efforts in mental healthcare. In the 1970s and 1980s, there was a significant "brain drain" of medical professionals leaving the island during ethnic conflict and war. The civil war severely disrupted healthcare (and mental) services and people's ability to access these services (e.g., via checkpoints). A major push to expand and decentralize mental health services came after the 2004 tsunami catastrophe. The national and international response to the disaster provided opportunity and resources to set up mental health units in districts throughout the island. With a heavy focus on community-based mental healthcare and psychosocial support, other key developments included the training and setting up multidisciplinary teams of mental health staff that would enable access to patients' homes and communities to assess and monitor their wellbeing and living conditions.

In the next chapter, I discuss how Dr. Ramesh actively worked to develop mental health services in Batticaloa District while trying to avoid the pitfalls and mistakes of the Angoda model. With opportunities to acquire resources from NGOs and international donors following the 2004 tsunami, he and his staff developed "friendly services," an intervention built on a recovery-based cultural model of care. However, as state and non-state resources linked to mental health services shifted since the civil war ended in 2009, mental healthcare practice has become more bureaucratic and medicalized.

Chapter 4: "Friendly Services": Leadership and the Development of Mental Health Services in Batticaloa District

In 1997, Dr. Ramesh and his wife—a pediatrician—surprised the director of mental health services in Sri Lanka when they requested to be posted in Batticaloa District. In 1995, after completing a one-year senior residency and working as a psychiatrist at Angoda hospital, Dr. Ramesh feared becoming indoctrinated into a system of care he described as "the Angoda model." In Chapter 3, I briefly review the Angoda model's historically rooted mechanisms and procedures of segregated treatment and management of mental and emotional problems, and the lasting lineage of this model. I also discuss ways this model is currently reproduced in Sri Lanka's state-run psychiatric services in Chapters 5 and 6. During one of our interviews, Dr. Ramesh excitedly conveyed his fears of becoming normalized to the institutionalized care of the Angoda model within Sri Lanka's mental healthcare system early in his career:

> So, wait, I'll tell you. So, roughly about a year, less than a year. I was so scared; I would be institutionalized, in a sense…you know institutionalization doesn't just happen to the patients, it happens to the professional also. Because after some time you normalize; you know, patients without clothes, staff meetings of patients, patients locked up for no real reason. Initially there is a sense of outrage and wrong. But when, you know that you don't have much power to change it, the only way to survive is to accept it as a necessary evil. Right? Normalize. And, and I was very scared that I would normalize. And I wanted to run away. So, me and my wife we had never been to Batticaloa before, we didn't have any contacts there…yeah, we thought we go…so the director of mental health services was like, "Brilliant! Great!" "Somebody going and asking him to be posted to Batticaloa at that time, at the height of the war."

It was rare for any consultant doctor to request a position in the war-torn areas, let alone a psychiatrist and pediatrician, both professions desperately needed in the region. After completing his required one-year international residency in England for postgraduate studies (MD), Dr. Ramesh and his family moved to Batticaloa in 1999. There, he found very limited services for managing psychiatric clients' needs at state-run hospitals. This provided him opportunities to develop services in direct contrast to the dominant cultural knowledge and practices driving state-run mental health services at that time. With limited access to patients, and a lack of bureaucratic restraints, Dr. Ramesh quickly went to work on improving access of services by developing

patient and community networks, a word-of-mouth reputation, and what he describes as "friendly services."

In this chapter, I examine leadership qualities and changes to institutional practices in mental health services in Batticaloa District following the 2004 tsunami, early global mental health interventions, and the civil war in 2009. My research mainly focused on two consultant psychiatrists, Drs. Ramesh and Chamil. Beginning at the start of the millennia, these two doctors played a major role in guiding staff and leading the development of social spaces, technologies, and cultural practices within mental health units in Batticaloa District.

First, I explore Dr. Ramesh's background, leadership qualities, and charismatic authority in managing state-run mental health services in Batticaloa district from 1999 to 2007. Under socially fragmented conditions of war and the 2004 tsunami, he established facilities (e.g., wards, clinics, etc.), acquired resources and staff, and expanded local access to state-run mental health services. His personality, charisma, vision, and "friendly" approach to recruiting and treating patients was less formal, instead, his practice was rooted in developing relationships and networks with patients, families, and communities. As such, Dr. Ramesh's efforts were effective in navigating social conditions absent of bureaucratic authority as services were not maintained or operating because of an overall lack of institutionalized structures, and because war and disaster disrupted "normal" standardized functioning of state-run healthcare.

Next, I examine Dr. Chamil's personality and vision, and how changes to leadership in mental health services in post-war social conditions have fostered a more systematic, medicalized, and bureaucratic approach. His efforts were aimed at greater sustainability of current inpatient and outpatient services, improving documentation within mental health units, and decentralizing clinics throughout the district. However, my findings indicate this approach led to a lessening of community-based mental health services, assessments, and treatments for distress.

I argue that Dr. Ramesh's charismatic leadership qualities and unique vision, and the social conditions of complex humanitarian emergencies (particularly after the tsunami) enabled

him to accomplish a lot (e.g., improve accessibility and develop services) in a short period of time. In this chapter, and Chapter 5, I show how acute care practices related to mental health services in Batticaloa District were significantly developed and then altered by the departure of a charismatic leader. Major shifts in the political, social, and economic situations at the end of Sri Lanka's civil war in 2009 also impacted service delivery, as well as changed the landscape of the social, economic, and political problems correlated to patient suffering. Given recent shifts in Batticaloa District's sociopolitical conditions and the differences between the professional styles and personalities of Dr. Chamil and Dr. Ramesh, I uncover tensions and struggles among staff and patients within and between mental health units.

Leadership and Global Mental Health

As Dr. Ramesh started to develop mental health services in Batticaloa District in the late 1990s, global health organizations like the World Health Organization (WHO) were beginning to place more focus on mental health and psychosocial issues. This is especially true following wars and large-scale humanitarian disasters. The 2004 tsunami impacted Sri Lanka on a uniquely large scale—e.g., the size of the disaster, global support and sentiment, and similar. State and non-state (e.g., World Bank, WHO, etc.) collaborations aimed to decentralize and expand mental health services in the country's outdated system, notwithstanding the limited availability of human and material resources.

Globalized humanitarian aid and support following the 2004 tsunami, experiences of trauma associated with large scale displacement and death, and the history and standards of mental healthcare in Sri Lanka, all spurred a confluence where funds and resources (both material and human) were shifted toward improving and expanding mental health services in the country. I provide evidence Sri Lanka was among the early low-/middle-income countries where programming patterns and trends follow what is now called "global mental health" (GMH). Among WHO literature on alleviating the global burden of mental or psychiatric illnesses, Sri Lanka is presented as a successful case for "building back better," fueling the rhetoric of GMH

interventions in the aftermath of disaster (WHO 2013). While quantitatively these successes cannot be denied, it is crucial to look beyond the numbers in order to examine the qualitative features of national, regional, and local approaches designed to improve and expand mental healthcare. In addition to collecting qualitative data with the aforementioned aims, I critically assess ways these interventions lack sustainability overtime as local settings, resources, and people change, and as the country transitions to a post-war society and economy.

Studies of global health often lack an on-the-ground analysis of ways local leaders negotiate within existing systems in efforts to build accessible facilities and services (Hanna and Kleinman 2013). These leaders must mediate between global health actors, organizations, and agendas, as well as state authority figures. They also contend with complex bureaucratic channels, pervasive views of state-run psychiatric/mental services, and the inability of many people to access services due to the war, a lack of money or support, as well as other socioeconomic barriers. As will be discussed this chapter, the personality of leaders and their different styles play a key role in shaping institutional knowledge and routines that structure doctor-patient interactions and relationships. In light of shifting political economic conditions, I analyze ways local leaders engaged with opportunities and managed challenges in their development of mental health services.

Ethnographic methods serve to illuminate how local institutional leaders shape access to mental health services, and, sociocultural routines of doctor-patient consultations in mental healthcare. Given the struggles and stigma tied to mental healthcare and illness in Sri Lanka (and globally) ethnographic research helps us to better understand what makes leaders effective at mobilizing a team, attracting financial and community support, and increasing accessibility of services amidst a global health trend to expand psychiatric services and resources. Specifically, my study captures qualities of local leaders that served them in navigating global health programs/endeavors and rapidly expanding “progressive” and “innovative” mental health services in Sri Lanka.

Anthropologists played a key role investigating matters of political practices, systems, and inequalities within the state (Scott 1998; Sharma and Gupta 2009; Spencer 2007). Considering rapid globalization, challenges to territoriality and sovereignty, increased privatization, and the "weakening" of highly centralized states, Sri Lanka presents an interesting setting to investigate ways leaders navigate limitations and develop mental health services. Additionally, in disaster-affected areas, there is a fracturing of bureaucratic procedures, and this splintering potentially provides leaders with greater ad hoc decision-making power to influence their organization in both positive and negative ways. The current chapter focuses on a qualitative examination of leaders in mental health units and aims to fill a lacuna regarding our understanding of leadership roles and political structures within health institutions and organizations, particularly tied to GMH.

Ethnography can illuminate ways in which people navigate state and non-state authority and shifts in status or rank. In this dissertation, I employ ethnography to elucidate how individuals—via relationships within broader and situational political structures—shape the social institutions they manage, in the present case, state-run mental health services. Most of my information, quotes, and analysis in this chapter come from my interactions with Dr. Ramesh and may present him in a favorable light. Perhaps this is because Dr. Ramesh provided more ethnographic data through his talkative demeaner. He also stood out with his unique, alternative approaches to treating mental illness. It was difficult for me not to be drawn to his story and ideas. My intention is not to show Dr. Chamil in a negative light or demonstrate that his approach and ideas are not as important. Rather, I highlight interview data that document the major qualitative impacts of economic and social changes largely occurring during Dr. Ramesh's prolific tenure as district consultant psychiatrist.

During fieldwork, I learned the first psychiatrist to come to eastern Sri Lanka arrived sometime just before or after a major cyclone that devastated the eastern shores in 1978. The cyclone killed over a thousand people, displaced over 100,000, and wreaked havoc on buildings

and infrastructure. In response to the 1978 cyclone, temporary teams were dispatched to provide basic healthcare services in Batticaloa District. These response teams included mental health and psychiatry services (Patrick and Patrick 1981). According to my research informants, a psychiatrist was placed in eastern Sri Lanka from 1978 until 1980/1981. However, this doctor has since died, and little information was been collected about him. What is known is that he established regular Monday clinics for those needing routine access to psychotropic drugs, as well as reserved a couple of beds for patients suffering from psychiatric issues in the medical ward of Hospital A.

Informants suggested he held "the Monday clinic" weekly, but others noted it was only once a month. He trained a couple of medical officers who ran the clinic after he left. When doctors observed patients with long-term or chronic expressions of psychosis and extreme, uncontrollable behaviors, or crimes suggesting mental illness, they were most likely sent on an arduous journey across the country to Angoda for treatment and possibly long-term habitation. This first district psychiatrist—whose name was not uncovered, only worked for two years in the east and then moved back north to his hometown of Jaffna. The legacy of his Monday clinics operated for numerous years after, yet as the civil war became more severe and there was a lack of medical officers to run the clinic, it was eventually shifted to the outpatient department (OPD). There, patients needing psychotropic drugs picked up their prescriptions after seeing a general practitioner.

Dr. Ramesh and Friendly Mental Health Services

I first met Dr. Ramesh in summer 2013 at Angoda hospital. In his 50s, with an unassuming stature and a receding hairline, I felt completely at ease while asking him questions. I was struck by the friendly and causal manner at which he discussed psychiatry. After our initial encounter, we met again in 2017. This time, we met at Colombo National Hospital where he was conducting clinic consultations. As a crowd of people stood, sat, and lined the hallway of the psychiatry ward, I squeezed past them to a compact consultation room separated by "office

dividers." True to his affable manner, he smiled, shook my hand while greeting me with look of recognition from our previous encounter a few years earlier.

Dr. Ramesh was born near Jaffna and grew up in different places around the country. His father worked as a postmaster and his mother worked as a teacher. Although his parents were Hindu, he was one of the few atheists I met in Sri Lanka. Dr. Ramesh's unique attitudes and viewpoints immediately registered as unconventional by Sri Lankan standards.

Looking for personal motivating factors, associations, and aspirations and dreams in his career and work pursuits, I asked Dr. Ramesh why he wanted to become a doctor. Given the country's limited career choices and opportunities, he discussed what drives someone into a career like medicine or engineering:

> You see in, in Sri Lanka…there are few avenues for money…doctor, engineer, lawyer, then maybe teacher. So there is a kind of hierarchy that we generally go through…So, it's kind of, not really a thought-out thing...But, doing psychiatry, yes, that was a clearly thought out decision for me…two reasons were there, one was…medicine, you know, general medicine or surgery. After some time, it becomes routine. You know…a particular surgery becomes very routine. And, ah, so, it would have become quite boring for me. Whereas mental health, like each client is different, each problem is quite unique in its own way. So it's much more kind of a stimulating and challenging. Another reason…there was always this kind of a north/south divide. You know, or east/west divide. Where the west had better services, etc. and the Asian countries, the poorer countries were always trying to catch up, that sort of thing. Because, you know, medicine as such is dependent on high technology and expensive interventions. Whereas in mental health, that gap is much narrower…I just need good people to work with, a good team. So, I could practice kind of, high quality mental health service. Even in very kind of, deprived areas of Sri Lanka…my parents were not too keen, they didn't oppose it, but I have kind of a grandfather who is a surgeon. So when my parents went and told him "yeah, Ramesh wants to do psychiatry." "Psychiatry! Why does he want to do psychiatry?!" But my parents were fine with it.

For Dr. Ramesh, psychiatry was interesting because of the diversity of cases and unique situations, and because of the little resources needed to manage psychiatric cases—less materials and technologies are needed when compared to other medical specialties. However, as Dr. Ramesh alluded to at the end of his quote, it carries perhaps the lowest status among medical specialties in Sri Lanka.

When Dr. Ramesh first came to Batticaloa in 1997, he was there for only three months. As mentioned, psychiatric services were non-existent. The only services available were the Monday clinics. Given the overwhelming negative associations with state-run mental health services, and his personal fears of being thoughtlessly conditioned into these services, it makes sense that he wanted to be placed in a district with little or no existing mental health services. However, setting up services would be no easy matter in the east with the civil war raging at that time. A lack of bureaucratic oversight, paired with Dr. Ramesh's charismatic leadership and drive, provided an opportunity for him to implement his own unique strategies to improve quality and access of mental health services.

When I asked Dr. Ramesh about initial barriers he faced while setting up services in the east, he stressed the main problem was "access." For him, it centered around three main issues: 1) travel to clinics or hospitals was difficult for people living in rural areas, especially during the civil war; 2) patients simply were unaware services existed and Dr. Ramesh had to find creative ways to recruit patients needing mental healthcare; and 3) fear or stigma surrounding "free" state-run mental health services. First, Dr. Ramesh conveyed problems associated with accessing services for populations under the strain and stress of war:

> Access. Access. You know, I mean, the entire area was off limits, coming to hospital was such a hassle…patients had to come all the way from Pottuvil, which is like 120 KM from Batti and Trincomalee, which is like another 150 KM. And there would be many checkpoints…Yeah, so every few kilometers there would be a checkpoint, so all the buses and all the vehicles would be stopped, everyone had to get down, and then walk, get them checked, go for another 100 yards, stay there until the bus will be checked, and then you get on…Right. So, traveling was the biggest problem.

Given these problems with traveling, Dr. Ramesh recognized the need and importance of regular transportation. His solution was to travel to rural or semi-rural communities to carry out outreach clinics, psychopharmaceutical injections, home visits, and similar activities, as well as to transport patients to wards or monthly clinics. With dismal funding for mental healthcare coming from Sri Lanka's Ministry of Health (MOH) and elsewhere prior to 2003, he had to find and

negotiate for resources (both material and human) from state and non-state actors. For example, he was able to procure a vehicle from the WHO to carry out mental health activities listed above.

Second, in order to recruit and build links with those needing services in Batticaloa District, he utilized techniques and ideas regarding "friendly care" and increasing patient accessibility that were taught to him by an influential professor of gynecology at the University of Colombo during his medical education. Such techniques and approaches for recruiting people with stigmatized or embarrassing health issues would prove fundamental to him, and influence his staff's efforts to improve access to mental health services. As he describes:

> [He] was an expert in very complicated surgery for ovarian carcinoma…he was a master at that. But there would be old ladies coming to the ward to get their hysterectomies done. You know, these old ladies will have a collapse, and would end up in the hospital for hysterectomies. And one of the rules this professor had was: you cannot postpone a hysterectomy. It is not an urgent, essential surgery…he wouldn't mind postponing them, but he wouldn't allow the postponement for these old ladies having the collapse. This is a very simple surgery. So I asked him one day, "what's your problem?" People were scared of him, but I asked him, and he told the reason. He said, "in a village there will be many women with the collapse, and they will urinate…they will have discomfort, they are shy to talk about it. And they wouldn't access services. Then one woman gets up enough courage to access the service." And for them, coming to Colombo being in hospital is a huge thing. And then, if you don't quickly dispose of them in a sense, getting them to theater, getting them operated and sending them back home. If you take them to the theater only to be cancelled and brought back again, and say, "you will have your operation tomorrow," "sorry we have another case, we are postponing your surgery by three days." She's going to go back with very bad memories. *[D: And talk about it, right?]* Talk about it…the other women in the village that were suffering from collapse aren't going to come. Right? So, that, was an important lesson for me…this is what happened to mental health as well, right, before we started the mental health services people will sell their house, land, take them to different paricaris because paricari treatment was not cheap. And they have given up, they don't try anything. And then somebody becomes brave enough, accepts the courage: ok, we will go to hospital and come. If he gave them a good deal, treated them friendly. Right? And we respect them, we don't scold them, and "why did you keep this patient for such a long time," you know, "why?" We don't do that…They go back, and the entire village is watching, "they went to the hospital, let's see what happens." Now there are no secrets in villages, everyone knows everything…They will go and ask this patient, you know, how did you go to the hospital? These are kind of experts now, and when they come to the clinic next time they will bring these patients. "Look, can you have look at her? She has headache." And most of the time their referrals are very good.

Here, Dr. Ramesh described the importance of treating patients with respect and providing "friendly care" to reach and inform those needing treatment in the rural village areas. Through word-of-mouth discussions, improved reputation, and gossip at the local level, community members and potential clients gained awareness and slowly developed a trust for physicians, hospital staff, and medical procedures.

Given the lack of awareness surrounding mental health services when Dr. Ramesh started working in Batticaloa District, he utilized his professor's ideas and strategy to formulate his plan to make services approachable and accessible. This meant treating with clients with respect, and he believed such efforts would provide quality services and build relationships and networks with patients, family members, and their communities. He knew developing relationships would help identify people who needed his care, as well as contribute to destigmatizing and normalizing mental healthcare among the district's villages and towns.

Given Dr. Ramesh's frustrations with state-based mental healthcare in reproducing poor services and maintaining fear, he needed to address and change historically rooted negative perceptions—i.e., those related to the Angoda model. He set out to make mental health services more friendly and informal. During his early months living and working in Batticaloa District, Dr. Ramesh received few patients and had ample unstructured time. His flexible schedule allowed him to get to know clients, network with staff and people located at the hospital, and become involved in hospital administration duties. As he described:

> …I mean, patients wouldn't come. They didn't know what a psychiatrist was…even the hospital staff didn't know who I was. Alright, so, I used to sit and play "cannon" [name of game] with my patients. The first few months. We became very good friends. [*D: Is there any other things you can think of that you felt was really challenging when you first started practicing beside awareness of the services? Or…*] Yeah, so, like…cutting the red tape was a bit of a challenge…patient can come and see me at any time during the working hours. For example, here [Angoda hospital] we have the clinics on Thursdays, and on another day, the patient wants to see us. There is no way, right? Whereas in Batticaloa people can like, walk in at any time and talk to anybody. We kind of had to cut out all the red tape. You know, those services are free; access is not always easy. And I suppose, it is better than some of the Western countries. Like UK, USA, but still there would be difficulties in accessing. And also, prioritizing mental health within the

> hospital, was also a little challenging. And, I mean, a great thing was [the director] was very supportive, and he helped…I got involved…in the overall hospital administration…And that gave me kind of additional power to negotiate with junior doctors, or nurses, or you know, take over this old building to start the ward. Right?

Dr. Ramesh understood that if he wanted to provide his friendly services, he needed to have some position, power, or legitimacy in the bureaucratic functioning and administrative duties of Hospital A. When he became acquainted with the director and other key staff, he could begin to carry out his mental healthcare and psychosocial support activities without bureaucratic hinderance or institutional surveillance.

To build mental health services from the ground up, Dr. Ramesh first focused on recruiting and treating those with serious mental disorders, people whom he considered most vulnerable and in need of psychiatric care. His friendly service approach was marked by three key features that were unique and differentiated from state-run standardized mental healthcare in the early 2000s in Sri Lanka. First, he utilized a recovery-oriented cultural of care for treating patients. Second, he fostered an informal atmosphere in the wards and clinics among patients and staff. Third, he negotiated with various stakeholders to make the most out of his opportunities to acquire resources (vehicles, etc.) and establish community-based programming, particularly following the 2004 tsunami relief efforts.

Dr. Ramesh took a recovery-based approach when treating patients in mental health services. This approach deviated from simply focusing on symptom control with diagnoses and psychotropic drugs, toward identifying mental healthcare practices that helped patient themselves take control of their problems and lives. Such recovery-oriented treatments assist patients in setting goals to foster personal growth and build resilience (Braslow 2013). Building off a recovery philosophy approach, beginning in 1971 near San Francisco, treatment programs began experimenting with a 24-hour facility that was staffed by non-professionals (not trained in psychiatry) who treated patients living with mental illness through encouraging shared, meaningful interpersonal experiences in a smaller, homelike, supportive, and safe setting (Mosher

1999). Treatment also usually involved little or no psychotropic drugs (or tranquilizers). This approach to mental healthcare is known as the "Soteria" method, which refers to the Greek word meaning salvation or deliverance (Mosher 1999). Though unaware of the Soteria method when he began services in Batticaloa, it aligns with Dr. Ramesh's approach in how he wanted to carry out treatments for patients, with some slight variations. As he described:

> So, so we worked out on the recovery model. Right, so symptom reduction was not always our goal. Right? It was about giving hope, giving choices, giving respect, for me those are as important as the medication. Right. So, it's a different approach…Ok, so what we used in Batticaloa would be called a modified Soteria model. Of course, when I used it in Batticaloa, I had not heard of this model… the original Soteria model was started in USA by a psychiatrist. And then, in America, they shut it down. Like most good things start in America…like a club house model, everything starts in U.S., and then shuts down. And now you have a few modified Soteria models in, I think, Switzerland, Austria, and maybe 1 or 2 in Germany, and UK as well. What is called "Modified Soteria." So what we used in Batticaloa…So they, because not having a professional background, not having, you know, the labeling and all that; they were treated as human beings. Right? And he showed lots of recovery. So he didn't use medication, and he selected the patient very carefully. Now we did two things different, we used medication, low doses. And, of course, we couldn't select the patients. We had to take all comers. And, of course, we used the nurses. But the good thing was the nurses didn't have any training in psychiatry. And, we were able to train the nurses to relate to patients as human beings, and not as labels. So no check lists, um, nothing."

In the district's mental health units, Dr. Ramesh and his staff did not use any restraints on patients and allowed males and females to mix and interact. In line with the Soteria method, he selected and recruited staff that were ideal for his treatment approach and trained them in providing friendly care, i.e., not to resorting to any kind of abuse, etc. His staff had not trained or worked in psychiatry or mental healthcare at Angoda hospital, which he saw as an advantage, and he encouraged them to be respectful and develop friendships with clients.

Building off the recovery approach and the Soteria method, Dr. Ramesh wanted to foster patient interactions with staff that made them feel at ease and to bring a "leveling" of status and authority between patients and doctors/staff. To do this, he chose not to take notes while conducting interviews or consultations with patients. He felt that scribbling down notes or staring

at paperwork made people uncomfortable and nervous. Dr. Ramesh also stressed the importance of building a relationship with both the patient and their family:

> …we would deal with the entire family as whole. Um, very rarely do you talk to a patient on a one-to-one…So very often you could be a group, family sitting together. Right? And, my number one priority was developing a friendly relationship with the client and family. Because, unlike other fields of medicine, usually our relationship with our clients goes a long way. So, we not only provide acute care in Sri Lanka…we provide the follow-up care as well. See unlike in UK or other countries where you would go to a psychiatrist just to get an opinion. But then you are followed-up by GP…our relationship with our clients are very long-term. Most for years, and the first contact is extremely important. So it is all very casual, friendly, people can interrupt me, and it's like that…Usually, very, very open in the discussions, right? I wouldn't have a pen or paper, or note, anything, when talking to patients…one, some people can write while maintaining eye contact. I can't do that. Two, when you start writing people do get worried, and I think it interferes in my relationship with my client. So, I do not write anything. So it can be causal conversation…all sorts of topics. So I don't use a kind of direct questioning, "Maybe you hear voices?" "Do suspect somebody is trying to kill you?" No. So it's all gathered in a much more indirect manner, which does take a little more time…but it helps to build rapport with the client. So I would write the notes afterwards. Ok, the patient will be sitting, and I will say "excuse me, before you go I want to make [note of] some things because I tend to forget." And very often, we would give the notes to the patients themselves. That's what we did. So, so, I don't use a check list of sort, I think it's kind of very restrictive…it's about the human-human relationship.
>
> So, very often, you know, patients coming for the second visit, they comment about my tie, my shirt not being ironed properly, my shoes not being polished properly, so I liked….families, parents, scolding me, I love it…So, so this kind of relationship that we tried to build with our clients…I would take my son, he was 3 or 4 years old at that time.…he would love to come to my ward, and even now, patients coming from Batticaloa and ask, "hey, how's [his son's name] doing?" Right? So, that's the type of relationship that we tried to build with our clients..So we made sure our ward was family friendly, kid friendly.

Dr. Ramesh would talk with the patient, discuss their problems and listen attentively to their responses. He did not want to control the flow of the narrative with a checklist of issues or questions to cover in consultations. Rather he would let the patient direct their own narrative, focus on building rapport with them, and assist them with developing ways to manage and take control of their mental or emotional problems. He would often hold these consultations outside, under a tree, or near the fish tank. He would feed fish with the client while they discussed a range of serious and casual topics like cricket. After the consultation, he would go back to his

paperwork and make a record of the conversation. I suggest that such personable and client-centered practices provided ways in which Dr. Ramesh resisted and pushed back on the Angoda model of mental healthcare tied to colonial and postcolonial psychiatric knowledge and practices in Sri Lanka. As discussed in Chapter 3, such custodial practices, and the history of poor state-run mental health services, often stir fear in Sri Lankans seeking out mental and emotional care. Indeed, as I found in my research, being associated with state-based, allopathic mental health services can degrade clients' status and their families.

Within mental health units, Dr. Ramesh fostered a sense of independence among staff in the way services were carried out. In order for his ideas and visions of mental healthcare and psychosocial support to come to fruition, he needed resources to reach people throughout the district and treat those needing services in a holistic manner—through multidisciplinary teams that better support patients' wide variety of life issues and struggles. This shift would also give mental health units a better understanding of patients' day-to-day lives while building connections with family members and other key relations. Opportunistically, he negotiated with various stakeholders from different disciplines, backgrounds, and organizations (WHO, community members, etc.), particularly in the aftermath of the 2004 tsunami and the surge of resources that followed. Dr. Thilagam was a WHO employee who supported efforts to expand and decentralize mental health services in Sri Lanka before and after the 2004 tsunami. He often worked with and supported Dr. Ramesh's mental healthcare activities during his tenure in Batticaloa District. As he described, "…after the tsunami, the WHO has given a transport to the districts, Batticaloa. Dr. Ramesh got support from the WHO at that time. Because he is a very active person. He always comes to the WHO and tries to get whatever support." (laugh). Dr. Ramesh has an incredible ability to network with a wide range of stakeholders (e.g., NGOs, LTTE, etc.) and acquire resources to advance mental health services in the district. Nadir, a Sri Lankan and trained anthropologist who lived, researched, and worked in Batticaloa District since the early 2000s, spent considerable time with Dr. Ramesh during the 2004 tsunami relief effort

and during his own ethnographic research on mental healthcare in Sri Lanka. Nadir described the situation as follows:

> …the abundance of resources at the time of the tsunami, which meant that suddenly you can build a network approach as opposed to like standalone services, and Ramesh was really good at that…And, there is a striking thing I observed, between 2009, 2010 and 2011; that things really shut down between these two years….Um, I think since then, the role of this mental health services…as an organizing principle has disappeared, particularly with the absence of leadership that Ramesh offered. And convening power and skill that he had, right? Um, I mean, there were a lot of things that were remarkable as a mental health service provider. And one of them is his ability to essentially put stuff together, keep people together, create, but essentially, he is not so big on structures, but quite big on function…

Dr. Ramesh sought out NGOs, private donations, and international governments to aid in building facilities and providing resources like vehicles, training, volunteers, and so on.

After the tsunami, Dr. Ramesh procured funds and coordinated with the Swiss Red Cross to build the first rehabilitation center in the district and in the east. He provided an example of when he used his skills to negotiate with administrators, community members, and leaders in effort to build a rehabilitation center to be used as an intermediate or long-term stay facility for clients who could be served through residential services. At that time, under conditions of war, setting up a rehabilitation unit for people living with mental illness in Batticaloa District was no easy matter given how mental illness is stigmatized. With limited community resources, he described working through the stigma surrounding treatment of mental illness:

> It [the hospital] was totally unused at that time. Brand new. Built and it was unused for five years. So when I wanted to start the rehabilitation center, the RDHS said, "yeah, you can use that." When we tried to use it, the community rose up against us, they said, "no, no, this is our hospital, this is for us," and blah, blah, "don't bring mentally ill people into our community." So this was 2002, when there was a cease fire between the government and LTTE. So we approached the LTTE to, you know, help us. So the LTTE also has a medical wing, had a medical wing. So they organized some meetings with the community for us to go and meet. And they said, "Dr. Ramesh wants to talk to you, see if you can help,"…They didn't try to influence at all. They were good, they were quite good. So we addressed the community and said, "look, this is for the district, this is a rehabilitation unit…." So we had a lot of meetings with the rural development staff, and then, at last, they agreed. And they said, "okay, we'll give it to you on two conditions, one, it is temporary, and two, our hospital – though built and unused for 4 or 5 years – you are to help us develop it." I said, "yes," I had absolutely no means of doing it, but I said yes. So

> we put up a small building behind it for vocational training. And at the time itself, we started this community integration...So we had a patient who was an ex-teacher, she started classes for the children from around the community, free. Because we had electricity, some of the houses around it didn't have electricity, children would come over to sit and study in the nights. So, that was a very good…

His efforts to build a rehabilitation center provided opportunities for patients and community members to socially engage with one another. Interactions occurred in a variety of ways, through incorporating patients who live at the rehabilitation unit into the surrounding community, and by allowing community members to freely and directly access the rehabilitation center at any time. This continuous social engagement with community members helped to foster less stigma surrounding people living with mental illness.

Dr. Ramesh was very effective as a leader in managing mental health programs in complex situations and in finding opportunities to improve these services in the face of social upheaval due to war and disaster. With his unique approach to mental healthcare and developing friendly relationships with patients, he put himself in an administrative position to have greater access to resources (such as procuring an old building at the back of Hospital A to establish the first mental health unit in Batticaloa District) and greater control over how he and his staff carried out services (such as not using any restraints, having a garden and large fish tank, spending less time at the hospital, and so on).

Dr. Ramesh worked to have two other mental health units built, one in the district and another in neighboring district. His efforts also included training numerous staff members, building of the rehabilitation center, and other various outreach and community engagement programs. All of these brought awareness to mental health issues. After working for eight years in Batticaloa District, his charismatic leadership qualities left a significant impact on mental health services and the staff providing care. Given global health and leadership successes are not easily quantifiable, Dr. Ramesh said he measured his successes beyond common statistical indicators and targets seen in GMH campaigns or interventions:

> So one of the stories I tell, after I came on transfer to Colombo: once I went to Batticaloa with somebody else for research or something, and on the way back I wanted to show her the rehabilitation center…there was a woman sitting and watching television…She heard the footsteps, right, and she looked me like this, and turned back at the television and said, "ah, you're coming now to see if we are alive or dead?" She didn't know I had gone and transferred, right? But, she didn't jump out of the chair and say, "sir" or something. She treated me like her younger brother…And the words she said, which is very common in Sri Lanka, like when you don't visit a relative at right, regular period…this is one of the questions that's asked, "ah, so you are coming to see whether we are alive or dead?" I was like really, really happy that she asked me that, because she saw me as a kind of…family friend…So, so this kind of relationship that we tried to build with our clients.

Dr. Chamil and Recent Mental Healthcare Practice

In 2007, Dr. Ramesh and his family moved to Colombo. There, he continues his psychiatric work and consultations in larger state-run facilities like NIMH (or formerly Angoda) and the national hospital. He is based in the capital, but his efforts continue and he still works to expand access and change the way mental health services are carried out in Sri Lanka.

In September 2009, after completing the required international residency in Australia for his postgraduate medical studies, Dr. Chamil arrived in Batticaloa and began his work as the district consultant psychiatrist. The personality and styles of Dr. Ramesh and Dr. Chamil significantly differ. Though they both obviously wanted to develop and improve the quality of mental health services, there are key differences in methods, particularly in regard to practicing systemized, medicalized, and bureaucratic mental healthcare. July of 2009 signaled major shifts to local social dynamics and the economy as Sri Lanka transitioned out of civil war. Leadership changes and socioeconomic conditions influenced the way services were carried out and led to a reemerging of historically rooted institutional methods and techniques (the Angoda model) for managing patients.

Located at the back of Hospital A, Batticaloa District's first psychiatric ward is a decaying building. The building houses male and female dormitories, staff rooms, medication/storage rooms, and small remnants of a garden established by Dr. Ramesh. Due to a lack of upkeep, the garden has now been reduced to a fenced off dirt patch surrounded by a couple of large trees. On a typical day it is common to observe what are called "ward rounds."

Every morning starts in typical fashion (with few exceptions). Nurses deliver injections and medications to patients and prepare the paperwork and patient folders for ward rounds with medical officers and Dr. Chamil. During rounds, they review, change, and sign off on next steps for patients admitted to the ward (e.g., drug dosages, treatment regiments and discharge)

As morning progresses, medical officers stroll in and begin filling out paperwork and organizing folders stacked on the table in the center of the staff room. As Dr. Chamil enters, all members of the staff—all except the older medical officers, Drs. Kanayama and Arthi—stand up as a sign of respect. Tall, thin, and well-dressed in shirt and tie, Dr. Chamil nods while broadly greeting staff, and quickly sits down to begin assessing the folders of patients to be seen that day. As he shifts through the files with lengthy fingers, he asks the medical officers and nurses about updates on patients while signing off on their "treatment request forms" and other forms documenting details related to patient care.

Following the morning briefing, Dr. Chamil begins his ward rounds with a crowd of staff members following closely behind. First, he usually visits the male dormitory, often passing a prison guard sitting outside the entrance. Inside, prisoners are cuffed to their beds next to "regular" inpatients accompanied by family members. As Dr. Chamil walks in, they jump to attention and briefly talk to "the big (*periya*) doctor" as he passes. He asks simple questions such as, "how are you?" and "any problems?" While he talks, other patients and staff squeeze into the dormitory rooms to observe the interaction between Dr. Chamil, the patient, and medical officer assigned to care for that patient.

Interactions with Dr. Chamil are typically brief, but some patients discuss their issues at length. On those occasions, Dr. Chamil usually acknowledges their complaints, yet, with little time to address them, he continues to make his way through the dormitories for updates on each patient staying at the ward. The length of time it takes to complete ward rounds varies depending on patient count, which ranges anywhere from 10 to 30 patients (sometimes more). After visiting both dormitories, in line with Dr. Ramesh's style (although not trained by him), Dr. Chamil

rushes back to the staff room to furiously fill out each patients' paperwork and discuss treatment plans. He usually spends an hour or less doing these "rounds" at the ward in the morning and sometimes afternoon, six days a week. Thereafter, depending on the day, it can be morning, afternoon, or both; nurses or attendant staff bring the patient and family to the staff room to further discuss the patient's regiment of care. Attendance at these individual patient meetings varies from 1 to 10 staff members seated around a table to discuss the patient's status. Patients and family members may be highly involved, or not at all.

These ward rounds are crucial to the institutional and bureaucratic functioning of medicalized care. The systematic management of inpatients checking the status and condition of admitted patients, establishing next steps in treatment such as changes to medications or dosage and reviewing decisions to admit and discharge patients. Dr. Chamil operates at the top of this system in the district, signing off on treatments that require his consultant authority—e.g., inpatient care of prisoners and prescribing certain types of medications. Upon finishing ward rounds, Dr. Chamil transitions to other administrative activities, these may involve training medical students, performing clinic consultations, supervising case conferences in the gender-based violence unit within the hospital, or attending to other clinics and wards across the district.

Hierarchies and formalities that exist between mental health staff, as evidenced in the daily rounds, may cause tension or anxiety for patients. Given this, it is not surprising Dr. Ramesh despises ward rounds. While working in Batticaloa and elsewhere, he insisted he never carried out ward rounds:

> No ward rounds…my theory is ward rounds are to boost the ego of the psychiatrist. (laugh) There are a lot of people sitting around a table and discussing about a patient, often in a language the patient doesn't understand. Right? It's a horrible, experience. There's no need for it. Right? So no ward rounds. Even in Angoda in my hospital, no ward rounds. So, most of the discussions with my junior doctors and the nurses will be how to manage the patients. And I will randomly go and ask them questions about, you know, how is this patient doing or whatever. So I know what is happening. And also patients always have access to me, come and complain to me, talk to me, all that…Finding solutions very informally. Not in a formal. Ok, let us sit down and have a meeting or something…Because the ward rounds are so stressful for patients, you go into

> a room, there are going to be a lot of people, doctors, nurses, and then you have to sit there, somebody will present your history. You know, say, "this person has anti-social personality traits, and has obsession traits, and the mother doesn't…" Horrible! Right. "He thought that others are poisoning him and now that is less, and now he thinks only his mother is poisoning him." …no way, no ward rounds. Because ward rounds are done to kind of, it's like kings having coats and stuff, establishing the picking order, is what I believe...

It is hard to say if Dr. Ramesh has an astute perception for recognizing hierarchies and inequalities in day-to-day interactions between physicians/staff, patients, and family members, but my observations and interviews indicate this in his style and practice of mental healthcare. The end of the war signaled important changes to institutional leadership, and mental health services in Batticaloa District. This period also occasioned shifts from less community-based programs and home visits to more centralized services at hospital or peripheral clinics; a task shifting of staff to emphasize managing symptoms, side-effects, and documentation; and, overall, a more bureaucratic and "systems" approach in order to sustain current services provided by mental health units. For Dr. Chamil, a shift was necessary to manage a much larger population of patients and given a recent decline of material and human resources at his disposal in the district.

Indeed, in comparison to Dr. Ramesh, Dr. Chamil leaned heavily on bureaucratic techniques and quantitative information for running or managing a healthcare system. I remember in my first few interactions with him in 2013 and in 2016. At Hospital A, we discussed my research project and what kind of data collection would take place. I showed him a sample questionnaire for my interviews with patients and he suggested that I develop a rating system for each of my questions: a quantitative spectrum to rate something as good or bad. Moreover, during my fieldwork, he consistently added forms and check sheets for mental health staff to collect information about patients (demographics, etc.) to inform and monitor their progress, as well as to utilize for research analysis. The staff used to joke about Dr. Chamil and his consistent use of new forms and surveys. In other words, for Dr. Chamil, documentation was very important to maintaining effective, sustainable medical practice.

For all their differences in personality and the way they carried out mental healthcare, there were some similarities. For one, both men came from the Jaffna region and married pediatricians. They were raised in middle-class, Hindu families, though Dr. Chamil still practices Hinduism and Dr. Ramesh does not. Dr. Chamil's father also worked as a government servant doing administrative duties. In addition to his interest in psychology before beginning his MBBS program at Jaffna, like Dr. Ramesh, Dr. Chamil was drawn to psychiatry because it was more holistic in nature than the other medical specialties, and because community-based programs were a part of contemporary programming in psychiatry.

Dr. Chamil began in the pediatric field, conducting relief work that covered several northern districts. He started psychiatric work in 1998, and later worked as a trainee at the National Hospital in Colombo. Like most professionals who work in mental healthcare in Sri Lanka, he completed forensic and general psychiatry duties at Angoda hospital for almost a year. Prior to 2005, Dr. Chamil also worked in Hambantota District in the south. After the tsunami struck the country, he was asked by the Ministry of Health to cover the Trincomalee area as his skills and Tamil language abilities were desperately needed to cover psychosocial relief efforts and carry out regular clinical and ward duties at established facilities. He later finished his postgraduate training in psychiatry and residency in Australia before he and his wife moved to Batticaloa District.

When he arrived in 2009, the socioeconomic situation in eastern Sri Lanka shifted from conditions of war to post-war development. President Rajapaksa and his regime rolled out state and privatized projects to rebuild infrastructure and foster "peace-building" in war-torn regions. In 2013, I noted Rajapaksa's face posted everywhere such as billboards for development projects, food trucks, and other places. Newly paved roads, an influx of commercial goods, and other dramatic changes to the socioeconomic situation in eastern Sri Lanka, coincided with a shift from a sense of collective war-related suffering, toward aspects of different, more individualized

distress related to career aspirations and social isolation and acceptance. As Dr. Chamil suggested:

> …earlier it was a challenge for assistance; hear about death and all those things; now it is about maybe…fear or anxiety about their progress, or their work or living, and other things, being accepted by others…earlier although the stress…was there, the collectiveness was there…[Now] They have to deal with their own issues; they are feeling like that. So that creates a lot of distress. They think that they are far behind when compared to others, so they would like to catch up. And it's, ah, sometimes high expectations also, with mental disorders, so it is an on-going struggle, as result of distress.

Mental health services were established and managed by Dr. Rita, Dr. Arthi, and others prior to Dr. Chamil's arrival and those accessing services continued to increase over the years. All state-run mental health staff interviewed suggested that the patient population has steadily risen since Dr. Ramesh started implementing mental health services in 1999. Dr. Chamil, in line with his professional approach, took a survey of patients over a five- or six-month period and estimated around 80% of patients accessing mental health-related services at Hospital A had no diagnosable psychiatric condition. He suggested these patients are dealing instead with psychosocial stress and distress-related conditions triggered by conflict and disaster, substance abuse, and microcredit lending practices. As he described, "Yeah, what I observed basically is, rather than identify mental disorders, the people are coming with distress; like suicidal attempts or self-harm is almost more than 80%…So that is something that's, ah, a bit unusual. When I left the country, it was not the situation. Because I worked in Trinco also, and it was not as such. So I have seen a huge difference in change of the client or patient population." Thus, a large bulk of patients admitted (either to the medical or mental health ward) for psychiatric services did not need, beyond acute treatment, psychotropic drugs and instead required sustainable and qualified counseling and psychosocial support, services that are scarcely available in the district and elsewhere in Sri Lanka. Historically, there has always been a low number of psychologists in the country, and most are located in Colombo.

In Batticaloa District, Dr. Chamil found, "[a] heavy workload, very dedicated and capable staff; [but] the system of care was not there…also limitation of the space." He suggested a proper system was not in place to effectively deliver services to an increasing patient population with various mental and emotional problems. In order to strengthen the current system of mental healthcare, he has worked toward: 1) implementing more peripheral clinics throughout the district, 2) ensuring better documentation practices, 3) filling voids by task shifting staff, and 4) better utilizing multidisciplinary teams and specialties for treating clients. As the district's only consultant psychiatrist with numerous duties inside and outside of Hospital A, he consistently labored to improve the mental health system and maximize his and his staff's time with patients during consultations.

Since the war ended, NGO and state funds have been significantly lacking and have shifted to other districts to improve their mental health services in the country. Dr. Chamil described a resource-low situation in which previous programs and services needed to be reduced in order to properly manage and treat current patient populations accessing mental health units. Dr. Chamil described working within these constraints:

> Still an on-going system, because of the changes to the staff and the number of the staff, and rotations…so, we have increased specialized services. So services have been expanded, but the resources are even lower from where we started…after some time there is sort of a mismatch also. Because services are expanded and you don't know how to reduce the services from where we started, but still struggle with available staff. We are still struggling in that sense.

For Dr. Chamil, this "mismatch" requires a better mental health system that provides monthly clinic interactions with people living in rural areas of the district so patients could access psychotropic medications without having to travel long distances. He suggested Dr. Ramesh's mental health programming lacked a proper system, given that he worked under emergency conditions and the programs were more ad hoc. Establishing a network of peripheral clinics throughout the district, Dr. Chamil suggests would make services more sustainable and specialized which, in turn, would allow doctors more time with patients. As he noted:

> Yeah, so, I think Dr. Ramesh has done a huge groundwork for that time…some of the current issues are not there. Maybe substance use was not much and these micro-loans, the suicides…this group is increasing, this group is more. And also that, even the normal people need some mental health professionals. Because we have to do it in a sustainable manner. Because now, at least, we have some space. There is no need for emergency care at this point. So, initially Dr. Ramesh, has done sort of an emergency model…which he has done very well. And the work, the NGOs also, he has a good relationship with NGOs and they support him. I think almost the same model we are practicing in Trincomalee when I was there…vehicles, and huge network of NGOs, and they will be able to support, and future money coming into these things. But still the same thing in Trinco, whatever they started, nothing stayed there. So sustainability is an issue. But there was a need for that time…And systems become very tighten, so it happened with no system at all. You can be very flexible, now of course, it is not easy, right? If you come at that time, you can simply come and discuss anything and stay there. Right? Nothing much, just a form, just to say what is the issue and what I am doing. Fine. Now, of course, you know how much difficulty: going to ministry, getting approval and getting answers…almost a system in place…what we tried to do is now we have established these outreach clinics, we are trying to have some community-based programs, right? …so as a team we are visiting a place and we do different activities on the clinic dates, right? So like school programs, institutional programs, similar child welfare centers…these peripheral clinics…if there are two doctors…if they spend about five minutes, maximum 30 people, so it will be roughly, each doctor will see about six; maybe around 30 to 45 minutes in the clinic will be over…So when more things will happen at the periphery that clinic will be looked after in a different way by the consumers. So people will stick to the [peripheral] clinic rather than coming to…[the] center. This is a patient care hospital, so what I thought here we will have specialized services…rather than just writing medications, right, we have only a few people…so I'm trying to change…our clinics into sort of multi-disciplinary clinics and specialized clinics. And the periphery clinics at the primary mental health clinics…

As socioeconomic conditions shifted, so too have patient populations. Dr. Chamil recognized the greater availability of resources and NGO support following the tsunami as well as Dr. Ramesh's skills in navigating that social terrain. Given the emergency conditions of the past, Dr. Chamil suggests that mental health systems needed to be flexible to handle such protracted social upheaval. However, absent an emergency, more systematization is needed to decentralize existing clinics and community-based activities to peripheral hospital spaces and sites. Utilizing a multidisciplinary team approach and improving specialized services at larger hospital sites, he suggests, will ensure healthcare providers have greater time to interact with patients.

Dr. Chamil worked to improve documentation and delegated tasks within mental health units. For example, he has implemented a better filing system for records, as well as designated spaces and assigned staff to talk with clients who he and medical officers are unable to accommodate due to limited time availability during monthly or weekly clinic visits. Such measures, he suggested, will help to systematically monitor changes to patients' distress and health-seeking patterns (i.e., if they stopped coming to clinics or come irregularly, etc.). As he described:

> Yes, so that's a big thing, so there is no report evidence, still we are spending a lot of time redoing the things because of the lack of documentation…that's a big challenge…But still slowly we are starting something like keeping files for each and every patient, so…if there are any changes we notice that…so whatever I am doing now is to tune the people to some documentation. Tell the people about, ah, levels of care…Now I have separated the rooms…elevated care and documentation…there are limitations also, [a peripheral clinic] is very small, but we have to play with that, right? And prisoner cases, we don't know how many there are, the number, and how to manage them. So that is a huge thing…

Dr. Chamil suggested within the current system of mental health services, he and his staff are unable to carry out a recovery-based approach to treating mental illness and emotional distress, as Dr. Ramesh attempted. Given the demands to spend more time with patients and the struggle to keep up clinical or ward services, Dr. Chamil told me they are:

> …more moving to that recovery model in a way, slowly. But we are preparing patients and the staff for that…they know that there is recovery, but they don't know what is recovery model and it is quite difficult because they think that if everyone is there, if there is multi-disciplinary staff is there, then it is sort of a recovery clinic…recovery is not something the symptoms are including, so it's more than that. Still a challenge to introduce that sense into the patient as an investment from the start. Like how to improve that also…informing the patient literacy about the drugs. So we try to talk about what the patient can talk about with a doctor, what they can ask from the doctor. So now they have no clues. As you mentioned, they don't know about their illness, they aren't knowing about their drugs, duration, so those are the things…With that, most of the gaps will be healed in a way with regard to the patient recovery…

Here Dr. Chamil suggested both patients' and staff lack an understandings of how to carry out treatment according to a recovery-based approach within current mental health services in Batticaloa District. Dr. Ramesh carried out services in alignment with recovery-based approaches

such as providing psychosocial support that extends beyond drug treatment of symptoms. It is not clear when and where these treatment practices faded from mental health units. In quite a different manner to Dr. Ramesh's approach (less traditional/bureaucratic), Dr. Chamil suggested a more systematized (more bureaucratic) approach would allow for recovery approaches to be possible.

Leadership and Personality in Mental Health Services

With his personality and approach, Dr. Ramesh had an incredible ability to develop and innovate mental health services. His leadership qualities could appeal to people emotionally and that allowed him to carry out services mostly uninhibited by administrative and bureaucratic structures under emergency conditions of civil war and the 2004 tsunami. Through utilizing a friendly approach, he created awareness, developed a reputation, and appealed to people living with mental illnesses. Though Drs. Ramesh and Chamil both had administrative duties in Hospital A, Dr. Ramesh was more likely to take risks, do first and ask later. Nadir spent considerable time with Dr. Ramesh and assisted with psychosocial support programs as well as coordination of tsunami aid relief efforts. He described some of the key differences between Dr. Ramesh and Dr. Chamil:

> I'll be a bit explicit. I think there is a very distinct difference in style. Like Ramesh privileges the open ended, the informal, the more kind of process-oriented kind of approach…is frankly irreverent when it comes to, you know, formal structures and authority. He uses nothing considerable, you know, social skills…and willingness to be either, you know, thought a fool of. He would find ways to, you know, he uses himself as a tool to get stuff done…You know, like he uses a wide range of interpersonal relational kind of approaches to get stuff done…pushes the envelope. Chamil offers a defensive way, much more structured, much less confident around, you know, like getting permission. Ramesh would do first and ask later. Right? Or, you know, he would just go in convince people to do stuff. And Chamil would like say "no," we should talk to the director of the hospital first. And in some ways…Chamil seeded a lot of autonomy that Ramesh had created for mental health services. You know, difference of structures, and, it kind of inherently…a system approach perhaps for the sake of a new system. It sounds great in theory, but actually in practice may not, um, you know, produce the same results.

Dr. Chamil's approach to managing and fostering creative problem solving among mental health staff tended to be restrictive at times, and institutional procedures (some implemented by Dr. Chamil, and others by the MOH or RDHS) may have hampered staff innovation and their ability to better provide care for their patients. As Dr. Rita described:

> Yeah, nowadays, when you go to one clinic, you have to wait for the vehicle, transport. In those days, we had a vehicle there; driver is there permanently. So, when we want to go on a home visit, suddenly we can go to the work. Nowadays, we can't go period…We have to get the permission…Earlier…All the things are under the ministry….Dr. Chamil is institutionalized. He [Dr. Ramesh] is community-based…This is the thing, that over control by the superior staff, now they are restricting movement, nowadays. Just this, we would not go to the director or RDHS, we would to Dr. Ramesh and go…Dr. Ramesh…knows that somebody is very interested and ah, keeping some good idea of psychiatry. He will go with them and enrich them…he wants it to be done by others…to involve everyone, the team.

Dr. Rita discussed the bureaucratic features restricting the autonomy and skills of medical officers trained in psychiatry. Dr. George, a medical officer at Hospital C, echoed Dr. Rita's sentiment:

> Yeah, accessibility. They can't access our services, even though we are having many peripheral clinics and all these things. Um, because our disease ourselves prevents the patient accessing our services. They [the client] can't come out, they need a supervising person, that's a basic thing. Because there should be more community developed service rather than a clinic or institutional based. Because still we are, even if you do a distance clinic, it is kind of an institutional one. So, community work and follow-ups are unnecessary…and poverty, and other things, accessibility is a basic.

Conclusion

In this chapter, it was not my objective to paint Dr. Chamil in negative light and Dr. Ramesh in a positive light in terms of what makes a great leader or who perform their jobs better. Rather, I aimed to demonstrate how key achievements in developing mental health services during Dr. Ramesh's period were, I believe, both a product of the social conditions of war, disaster, and aid relief or humanitarian relief support system, and a result of Dr. Ramesh's personality and ability to navigate these environments and people, to gather support and funding to practice his cultural model of care. When I asked Nadir about the difference between Dr. Ramesh's and Dr. Chamil's leadership, he said:

> …I would say, a huge amount of it is actually personal style, and capacity. Um, and skills and so on. And, of course, that does intersect with resources, right? So, the growth of services and so on; it also coincided with a period of abundance in some ways. But, the fact that Ramesh channeled those things into things that mattered…he went to Canada and gave keynote address somewhere and basically asked for money for the ward, and that ward was built, right? Like that kind of thing. Like, regardless of the circumstances, you know, you make the best of it; you have the capacity to do that…Ramesh spent most of his time outside the hospital, right? Because he said, "I don't really add that very much being in the hospital." Like I add more outside. Um, I think I interviewed him, and he was like, "for the problems, if we take an individual approach using me, like there is 1.7 million people." Which was at the time when I first met him, it was like the three districts, it was just him, right? It makes no sense. "I can't make any kind of contribution, I can't make any dent in the numbers...

The work culture and programs established by Dr. Ramesh lingered among the staff in mental health units and became instilled in institutional practices.

Differences between Dr. Ramesh's and Dr. Chamil's leadership styles and vision of care that were presented in this chapter had an impact on treatment practices, but also caused tension among the staff. These tensions, conflicts, and differences are important to the next chapter, where I present an analysis of doctor-patient consultations and medicalized and bureaucratic routines within mental health services. Changes to leadership and transitioning from a war to post-war context meant Dr. Ramesh's services and community networks lacked sustainability. As district resources that were provided by the WHO and other international funders faded and shifted to other health programs, Dr. Ramesh's "friendly services" of mental health have not been fully practiced since his departure.

Chapter 5: "Doctors are Gods": Medical Officers' Strategies and Medicalized and Bureaucratic Routines in Doctor-Patient Consultations

The phrase "doctors are gods" was used by Dr. Arthi during one of our interviews. The phrase suggests a certain amount of authority over patients' healthcare choices, where Sri Lankans follow doctor orders without question—especially people considered to be lower class, caste, or lack education. I heard this phrase multiple times in reference to the high status of physicians, and also to qualify a sense of passive compliance in the face of such power-laced encounters within the cultural authority of medicine. When asked about doctor-patient dialogue during consultations, Dr. Arthi replied:

> Normally they are not asking questions to us. We are asking the questions. If a person is educated, only 20-30% are asking questions…They are mostly quiet…Because our people are thinking "doctors are gods," no? Otherwise, a lot of history they will give. But that we are asking. They are not ever present. They are feeling less powerful.

Medical officers and Dr. Chamil also spoke numerous times about the importance of educating patients and family members about drug compliance and psychiatry (i.e., biomedical/allopathic understandings of what are the causes of mental illness and patient distress). Dr. Arthi consciously recognizes the power dynamics of doctor-patient consultation, and, like other medical officers I observed in Batticaloa, she used personalized strategies to engage with patients that challenge traditional hierarchies to make patients feel more comfortable when meeting with her.

Dr. Arthi's family history of education and practice in the healing arts, especially ayurveda/siddha medicine, were briefly mentioned in Chapter 2. Her daughter worked as an allopathic physician in Colombo. Both she and Dr. Kanayama were the senior medical officers within Hospital A's mental health unit. They were the only staff members who were not expected to stand up when Dr. Chamil (the "*periya* (big) doctor") first walked into the room. Dr. Arthi always brought a furnace filled with hot tea. Every early afternoon, she would take a tea break between ward rounds and often share with Dr. Kanayama. She would never put sugar directly

into the tea, mainly due to her hyperglycemia, but would take little spoonful of sugar and toss it into her mouth.

Most people who meet Dr. Arthi often remember her constant displays of humor, laughter, and rapid speech in Tamil and English. One morning she came into the staff room and looked at me with a shocked face. She walked over and put her on my stomach, saying, "you are looking so fat." She then turned around and laughed with the other staff as she walked to the main table filled with patient folders and other paperwork. Given the power dynamics between patients and doctors, to put patients at ease, she would use humor and make fun of herself. For example, in consultations, I heard Dr. Arthi multiple times use the English term "loose" to describe herself and personality. In popular Tamil movies and media, "loose" implies someone is a little crazy in joking manner. Quite different from the Tamil term *paittiyam*, which mostly has negative connotations attached to it. I never heard medical officers use this term when conversing with patients.

Through their use of language, humor, personal struggles, and other relatable strategies, medical officers like Dr. Arthi connected and built relationships with patients and family members within mental health units in Batticaloa District. Even so, my research documents ways mental health units have become more bureaucratic and medicalized in the face of challenges to maintaining the "friendly services "established by Dr. Ramesh during the civil war period. The continuation of the current bureaucratic and medicalized systems of mental healthcare, I argue, threatens to de-skill medical officers and lessen their abilities to help patients manage social determinants of mental and emotional distress (or "idioms of distress").

In the previous chapters, I document two major trends in the social transformation of medicine and psychiatry in South Asia and Sri Lanka. First, among allopathic physicians, traditional healing is often viewed as abusive or a threat to psychiatric practice. Specifically, traditional healers may disrupt psychopharmaceutical usage and compliance as well as the emotional stability of patients. Second, a modern history of psychiatry in Sri Lanka evidences a

lack of consist resources, patient overcrowding, and an overstretched medical systems. My research links a complicated history of a present-day reliance on medicine, bureaucratic procedures, and patient compliance; mechanism that maximize services with limited resources. As part of the historically rooted cultural knowledge and authority of doctors and biomedicine in Sri Lanka and globally, doctor-patient-family member relationships and dialogues are condensed, displaced, and decentralized in medicalized and bureaucratic processes in resource-stretched mental health services in post-war Batticaloa District. Such medicalized approaches can have negative and positive effects depending on the patient, family member, and doctor/staff. In this chapter, I illuminate bureaucratic and medicalized routines evident within doctor-patient consultations and relationships. I document medical officers' personalized strategies that both reinforce biomedical and bureaucratic practices but also break away from these institutional patterns.

As discussed last chapter, mental healthcare practices that influence doctor-patient consultations have changed when Dr. Ramesh took another position in Colombo and the civil war ended. Sociopolitical changes, such as increased commercialization and access to goods/services (cellphones, loans, vehicles, etc.), have affected residents and doctor-patient consultations. Indeed, many informants suggested there was an influx of commercial goods and micro-credit loan opportunities that were not available previously. Clearly discussions within doctor-patient consultations directly related to socioeconomic changes happening around these institutions, but as shown in anthropological and sociological studies of doctor-patient interactions (Crandon-Malamud 1991; Waitzkin 1991), medical procedures can shift and mimic societal changes.

Consultations reflect tensions and upheaval within patients' lives and social settings. The interconnected personal and family troubles that typically comes with loans are compounded by unexpected problems like droughts or interpersonal family conflicts. Ambitions to attain motorcycles, cellphones, nice homes, and other status symbols—including adhering to certain gender-roles, such as those involved in securing homesteads as dowry—spill into doctor-patient

interactions and treatments. Staff try to manage these issues while personalizing their approach and strategizing the best way to carry out services.

During Dr. Ramesh's tenure as the district's consultant psychiatrist, consultations were organized around "friendly care" and modeled on a "recovery-based" approach to mental healthcare. Using his vision, and availability of humanitarian relief following the tsunami and during the war, Dr. Ramesh performed less rigid and bureaucratic consultations. His method of service delivery increased the legitimacy of mental health medical services in the area and built networks of trust between locals and those accessing services. As part of his friendly services, Dr. Ramesh sat with patients in the garden, without paperwork, and casually chatted with them. Only after their talk, he made notes in notebook and completed standard hospital paperwork (e.g., daily state forms, admission forms, treatment forms, etc.).

Since Dr. Ramesh's departure in 2007, mental health services in the area have struggled to maintain a recovery-based, "friendly services" approach to mental healthcare. Services have shifted with staff overturn, increased patient numbers, and the end of the war (i.e., less monetary aide, and a change from outreach and ad hoc types of programs). As reflected in this chapter and last chapter, institutional mental healthcare practices that shape doctor-patient consultations have become more medicalized and bureaucratic in mental health units. Yet, most of the medical officers working in the district at the time of this research were either influenced or trained by Dr. Ramesh. In the current chapter, I investigate routine clinic and ward interactions, gathering and analyzing data in order to under the medicalization of distress, how people learn to navigate services, and the ways in which physicians resist/or maintain bureaucratic routines of doctor-patient consultations within mental health units.

First, I examine anthropological literature addressing doctor-patient consultations. Specifically, I discuss common themes regarding state-based interventions, and the ways patients and doctors/other staff navigate contextual problems happening inside and outside the hospital. Second, I analyze how patients initially entered state-run mental health spaces and key

sociopolitical routines both before and after doctor-patient consultations. I discuss routine social interactions between doctors and patients in mental health units: clinics, wards, counseling/psychotherapy, and home visits. This chapter does not cover client experiences prior to entering biomedical spaces; however, broad health-seeking narratives are covered in the next chapter. I built stronger relationships with mental health staff and, in this chapter, analyze personalized strategies and meaning making acts observed in doctor-patient consultations and related mental health unit activities.

Third, I provide an ethnographic description of a "clinic day" at Hospital B to illuminate bureaucratic routines of doctor-patient consultations, interrupted only for extreme behaviors. Clinic routines centered around pharmaceutical symptom management and drug compliance, management of risky and unstable individuals with major or severe mental disorders, and directing family management of these types of patient. I discuss ways medical services want patients and family members to learn drug compliance at the same time creating dependency and passiveness—part of learning to be a patient in mental health units. These features are even more pronounced as the length of doctor-patient interactions become more scarce, bureaucratic, and constrained within a system lacking human and material resources.

Focusing on these three issues, outpatients and psychosocial determinants of distress get little attention by doctors, as most outpatients are referred to another mental health staff member (e.g., nurses, psychiatric social workers) or to outside organizations (e.g., district or divisional secretariats) for counseling or social support. Ethnographic data indicates a neglect by mental health staff of broader socioeconomic stressors among clients. Mental health services centered around managing clients so they remain emotionally and mentally stable and are not re-admitted to wards. Though drug compliance is crucial to maintaining mental and emotional stability among a set of patients, if outpatient services developed to address patients' broader, social determinants of distress in medical consultations, it may make patients more resilient and keep them from needing to be checked into the ward. In this chapter, I focus on how social determinants of

distress are dismissed, ignored, or mystified in medicalized and bureaucratic practices. This study provides perspective for how medicalized and bureaucratic practices can marginalize contextual issues and disrupt or fracture therapeutic relationships between doctors, patients, and family members.

The Anthropology of Doctor-Patient Consultations

To begin, we must analyze anthropological literature examining medicalized and bureaucratic sociopolitical characteristics and cultural practices of westernized, state-based medical systems. Anthropological research on healer-patient interactions dates to the modern origins of the discipline in the 19th century (e.g., Rivers 1924). Early advancements in studying westernized medical interactions mostly come from sociology in the 1940s and 1950s, as anthropologists were focused non-western medical and locally based healing traditions. Utilizing a Durkheimian, functionalist perspective, these sociological scholars tended to view society through a body metaphor—society as a system of interconnected parts working together to ensure social equilibrium (like bodily homeostasis) (Merton 1968; Mills 2000). As such, social institutions like healthcare and medical services perform functions for the larger society.

From a functionalist perspective, Talcott Parsons (1951, 1975) suggested when people became sick or ill, they took on what he described as "the sick role." The sick role sanctioned abnormality or deviance ("not at fault") for sick individuals unable to be a productive member of society. When one took on this role, in a vulnerable state, they were passively dependent on doctors to be cared for, but obligated to return to their normal life as a productive citizen. Given the wide variety of deviant behaviors in societies, people's sick role may be conditional, unconditionally legitimate, and illegitimate (Parsons 1951). In the numerous years since Parsons's work on medicine and illness in society, this perspective has been widely critiqued by anthropologists and sociologists alike for failing to capturing how social inequalities are reproduced in medical encounters, as well as for ignoring individual strategies utilized by patients and doctors in navigating medical systems.

Utilizing a more critical lens on medical establishments, in his book "Asylums," Erving Goffman's (1961) ethnographic research in a Washington D.C. mental asylum in the 1950s illuminates how people assume moral careers that involve changes in the way people judge themselves and others. According to Goffman, such changes to the self can be degrading to one's status and teach passiveness (i.e., limiting self-expression or meaning-making acts) within highly controlled environments such as institutionalized psychiatric facilities, which he referred to as "total institutions" (Goffman 1961, 4). With decentralization of medical and psychiatric services in recent years, total institutions for mentally ill patients have become less common. Likewise, given contemporary forms of globalization, the boundaries of psychiatric services in Sri Lanka and elsewhere have become more permeable and decentralized.

In Marxist or political economy perspectives, state-based ideologies and institutions are a crucial part of reproducing social relations of capitalist production and domination. Examining macro-level structures or politics that contributes to social inequalities, critical sociological researchers have looked at how these macro-level political processes are mimicked or reproduced in micro-level doctor-patient interactions. Waitzkin's (1989, 1991) research on doctor-patient consultations in the U.S. shows that there are common discussions and routines of medical encounters, in which physicians use communicative techniques (consciously and unconsciously) to avoid, dismiss, or mystify contextual problems linked with medical conditions and life problems. Waitzkin's research shows ways medical encounters reinforce macro-level ideologies. Using tensions, habits, mistakes, or other features that disrupt bureaucratic routines of medical encounters, his qualitative research sheds light on where medicine fails to resolve patients' illnesses beyond symptom control and social determinants of illnesses, which, in turn, reproduces macro-level social inequities and ideologies (see also Browne 2007; Cooper 2015; O'Neil 1989).

Waitzkin's political economy approach to studying doctor-patient interactions is crucial for understanding the macro-micro social dynamics happening in medical institutions and interactions. It is, however, limited in capturing tensions and contradictions beyond conversional

analysis and audio recording of medical encounters. Ethnographic research on biomedicine in local clinical settings has become more common in anthropology since the 1980s. Here I hope an ethnographic perspective sheds light on contextual issues (as Waitzkin discussed) and personal backgrounds, particularly regarding medical officers, that affect conversations and procedures of mental health interactions. Infusing a political economy perspective with interpretivist and psychoanalytic approaches, anthropologists have illuminated greater local understandings of doctor-patient interactions and medicalization in and outside of the U.S. and European societies (Crandon-Malamud 1986, 1991; Good and Good 2000; Stein 1985). They demonstrate how medicine is not simply reproduced across national boundaries, documenting but cultural variability in medicalization, biomedicalization, and institutional routines of doctor-patient interactions. In an era of global health, anthropologists must work to demonstrate ways in which doctors and patients improvise and deal with social problems in post-colonial resource-low settings, often tied to neoliberal trends such as increased privatization of healthcare, decentralization, individualism, and healthcare procedures that are driven and determined by markets (Addlakha 2015; Ecks 2014; Livingston 2012; Nunley 1996).

Building on this anthropological research on doctor-patient interactions in an era of global health, I utilize Obeyesekere's concept of "the work of culture" and Wolf's ecological understandings of power dynamics to articulate ways of biomedicine or allopathic medicine are specialized (in psychiatry), localized, and performed or rejected by medical officer respondents in Batticaloa District. This chapter focuses on personalized strategies used by medical officers in consultations, and how these personal strategies to negotiate with medicalized and bureaucratic routines.

Arriving at Mental Health Units

Hospital B was located about 40 minutes away from my rental house in Batticaloa District. I rode my motorcycle regularly to the mental health unit there to observe Dr. Pradeep's consultations with patients. On the way, I could not help but notice the numerous military bases

(e.g., Artillery Unit 65, etc.) with the typical barbed wire, mounds, and guard posts that lined the main road running up and down the district. Clearly some demilitarization occurred since the war ended. I remember passing barbed wire fenced-off areas with large "X"s and "area de-mined" spray painted on the metal gate entrances.

In reality, I only had one experience in 2013 with a military checkpoint. Riding to Jaffna with a friend on the bus, he warned me that we would have to get off, and then they might check bags. On this trip, they did not check our bags, but they did check them on our return trip to Batticaloa District. Then I would need to talk to personnel working at the checkpoint. He knew my research interests in psychological trauma and war-related experiences (at that time) may raise suspicion, so he asked, "what will you say you are doing?" I said, "I'll just say I'm a tourist." He looked at me with excitement and said "okay" with smile on his face. When we got to the road block, the passengers walked through the checkpoint and one of the military personnel pointed for us to go speak with a man sitting at a table. We walked over and I handed him my passport. He glanced briefly at my friend and I as we sat in the two chairs in front of the desk. He looked through my passport and asked, "what is the purpose of your visit?" The big moment. I said, "tourism." The man then handed me back my passport briefly and waved us on our way without a second thought. All the passengers got back on and my friend looked at me and said, "you are tourist" (laugh). Needless to say, it is difficult for me to fully understand what it was like to live under war-related social conditions.

War-time military checkpoints severely disrupted and delayed people's travel throughout the district. During Dr. Ramesh's tenure as the consultant psychiatrist in Batticaloa District, patients had little money and great difficulty getting to clinics for their medications and other services at mental health units. Given these problems of accessibility, he eventually had ID cards made to identify his patients as having a mental illness. Though this sounds like profiling and further stigmatizing these individuals, these cards were highly popular and valued by patients and family members. These IDs could literally mean life or death for a Tamil-speaking patient if he or

she started acting out of hand while at a military checkpoint. Through the authority of Dr. Ramesh's status as a doctor, these patients and family members were not hassled and went more easily through a checkpoint with an ID card. Mental health staff during the civil war were able to procure funds from NGOs to give to patients at monthly clinics in order to lessen the burden of time and cost to travel from rural areas in the district. Now, such funds do not exist, and the cost of travel has gone up in recent years. As local medical officer Dr. George describes, "Usually it is the poverty among our area. That's the main thing, they can't travel. Now, you know, they increased the bus fares also. So, it's very difficult for them to come." I observed and interviewed various patients who struggled to get to monthly clinics from rural areas due to the cost of transportation.

There are very few fixed military checkpoints left in Sri Lanka these days, but there are other poignant symbols everywhere of surveillance and control. Such displays of power and state-sanctioned ethnic and religious violence can be seen in state-based institutions and public places, processes happening both on a large social scale and in micro-level social interactions. Three years later, in 2016, I took the same bus journey to Jaffna with two middle-aged priests who I befriended while staying in a hostel in Batticaloa District. While on the way to Jaffna, I was tightly shoved between the two priests—dressed in casual clothing—in front of the bus. We were long enough into our journey north that we had stopped talking and tiredly starred out the window at the road rolling in front of us. The bus was fully packed, with people standing in the aisle, getting on and off between towns. The letters on signs became increasingly Sinhalese.

At one stop, a Buddhist monk stepped on the bus, dressed in the typical all orange robe. In Sri Lanka, there are designated areas that allocate seats for pregnant women, clergy members, and people with disabilities at the front of the bus. In other words, someone should give up their seat to allow them to sit. This rule is posted above the first rows of designated seats. My friends often traveled back and forth on buses between Jaffna and Batticaloa District, and had made sure to reserve our seats over the phone. I am not sure if a sign was posted on above the three seats we

were occupying. The monk walked on the full bus, looked around, and was appalled that no one was offering him their seat. He then looked at the plain clothed priest sitting to my left near the aisle and forcefully swung his satchel, striking my friend. You could feel the tension on the bus become heighted, but people acted quickly to defuse the situation and someone offered their seat to the monk who starred angrily at my friend as he moved to his seat. My friend sat stunned and socked in his seat while small, quiet conversations followed.

On a larger scale, one can see the rapid deployment of state military-police forces during states of emergency or moments of crisis (e.g., 2017 anti-Muslim riots in, 2019 Easter bombings), and for campaign or political events. I once observed a campaign rally for President Sirisena held in a field nearby a main road in Batticaloa District, in which they had special commandos and police posted with machine guns every block for at least a mile. When I began my ethnographic research, I wanted to conduct patient-doctor observations in a large, semi-rural ayurveda hospital. But I changed my mind after meeting with one of the main doctors a few times, he eventually told me in a low voice, "you know, there is a military base nearby here. And they are coming often. If they see you and began asking questions…and you are looking at psychological issues, no?" Clearly I did not want to put any physicians and clients at any unnecessary risk during my research, so I chose not to carry out observations at this ayurveda hospital. However, the ayurvedic doctor's comment points to everyday forms of state-related surveillance and the close proximity of people's houses, hospitals, and other social institutions to military bases and soldiers.

The road leading to the village where I stayed while in Batticaloa District ran along a lagoon. During certain times of year, late at night, you could observe lanterns lighting the edge of the lagoon, fisherman catching shrimps or crabs, or fishman lights on the distant ocean. During the day, a dense pattern of advertisements for microcredit loans for 45,000-80,000 LKR attached to light poles, billboards, and fences. I regularly observed counseling sessions with men and

women who attempted suicide due to distress associated with loan problems—whether it be related to marital conflict or personal shame.

A consistent discussion of discontent among younger male patients revolved around their desires for new motorcycles and other status symbols. A motorcycle is a major symbol of freedom and independence. In Tamil movies, heroes regularly drive motorcycles on their hero's journey, do fancy tricks, and get the heroine. I remember seeing a Facebook post from a local friend riding with a caravan of all-male motorcycle riders celebrating an action Tamil film release. Online social media posts of motorcycle caravans or other public displays of celebration, status, and/or protest are quite a regular occurrence in eastern Sri Lanka. With greater access to technologies and other goods, people's stressors have clearly shifted since the civil war ended in 2009. As Dr. Pradeep described:

> I think it is many stressors. One is the money. Second, they cannot settle the loans in time…the moto bike, and they get another problem. And frequent accidents. So, these kinds of emerging problems, we observe once the war was over in 2009. And also substance abuses, they also do not know what is social drinking…what are the limitations…how to manage the electronics, how to handle the net. So, there are many positive sides, but they go for the negative side…I have a moto bike for the purpose of traveling to my work. But if the adolescent has a moto bike not for that. He wants to show some magic, some advertisement…they go for the public places.

With popular representations in movies and other media, in consultations, he and other medical officers' encountered distress associated with status symbols such as cellphones, motorcycles, and other items that influence people's desires. In counseling sessions with patients, I listened to ways people motivated by and seeking to obtain such statuses spiraled out of control and racked up debt.

Dr. Pradeep took the same road to Hospital B five or six days a week on his aging Honda motorcycle. He had a vehicle, but he and his wife mostly use it for family trips, touring people around the east, and other special occasions. One day, while chatting in the little dirt parking area outside the mental health unit at Hospital B, he proudly proclaimed, "it has more than 200,000 KM." Perhaps representative of the way he practices medicine, its simplicity, durability,

mobility—i.e., not powerful physician with a car and white coat or dressed up (it is important to note that doctors get tax breaks for vehicles, which are usually very expensive). Such feelings sentiments go along with common cultural stereotypes and generalizations that I had heard about eastern Tamil-speaking people and regional differences.

I recall an interview with an occupational therapist (OT) who worked with the mental health unit at Hospital A. She expressed some of these stereotypes and sentiments: "In the east," she said, "we will invite strangers into the house for tea. But in the north, in Jaffna, if you are stranger, they will not invite you into the house or offer you tea…They also say people from the east are lazy and uneducated." In order to verify her statements, she called to her husband in the other room who is from Jaffna and works as a physical therapist at Hospital A. She repeated her statement and he said, "yeah, it is true," then he walked back to the other room.

Dr. George expressed a similar sentiment about psychiatric practice and team members in Batticaloa: "Our consultants will go indirectly, go sit in the sand (laugh), all the staff will talk with the patient on the street (laugh)…It is more towards like that. Ah, he will go to home and eat with them and discuss things. So, we also practice that closely. So that is the difference I can see. Jaffna, other places, it is more like the official method. It is like, um, sitting at the table, patients sitting in their allocated place, every chair and arrangement is there." These comments by Dr. Pradeep, OT, and Dr. George highlight how medical officers and staff fashion themselves and their practice of mental health in alignment with Dr. Ramesh's practice of mental healthcare and regional cultural tropes, imagery, and generalizations about the east, which makes them distinctive from other mental health units on the island.

Types of Social Interactions with Patients

In this section, I discuss social routines and features of accessing and leaving mental health services. I present data and analyze interactions before and after the doctor-patient consultation, as well as document types of staff-patient-family member interactions within mental health units. As I discuss in the next chapter, there are numerous routes that led patients to access

mental health units. They may go through a variety of healthcare options and referrals from various people (neighbors, friends/family, private hospitals, police, traditional healers, etc.) before arriving at a mental health unit. It is important to note the duration, seriousness, and severity of illnesses (e.g., expressions and behaviors of clients and the associated reactions of family members) influence how patients are introduced to psychiatric mental health physicians in Batticaloa District. In some cases, patients travel long distances to see Dr. Pradeep, Dr. Rita, and other staff. Their journey may be motivated by a variety of reasons such as a lack of Tamil-speaking doctors, to avoid being seen by others (stigma), ineffective experiences with traditional healers (*paricaris*), and/or frustration with treatments at other mental health units within and outside of the district.

Social interactions within mental health units in Batticaloa can be classified as: 1) clinic (outpatient), 2) ward (inpatient), 3) home visit (outside), and 4) counseling/psychotherapy. As discussed, mental health units are organized around interactions that include social encounters before and after clinic-related, ward-related, and other activities. I explore the spaces where these activities take place as well as interpersonal exchanges (e.g., discussions, documents, medications) among patients, doctors, family members, and staff. Research examining these illuminate social learning and meaning making acts that accompany accessing and working within mental health units in Batticaloa District.

I use "clinic" to refer to the treatment and management of outpatient care and drug distribution. In Hospital B and C, these interactions occurred in consultation offices within mental health wards. Clinic consultations also took place outside of Hospital A, B, and C at an assigned room in "peripheral" clinics within smaller and more rural hospitals. At Hospital B, these interactions took place in Dr. Pradeep's office on Mondays and Thursdays. His office was airconditioned (AC) with a couch, a couple of chairs, a small desk with a computer, and a large desk with a file organizer containing various hospital forms. Dr. Pradeep usually ran his AC full blast. I would often notice patients shivering under the AC unit blowing directly on them during

the consultation. Hospital C's consultation office had an open grate window near a small sewage that brought a lot of flies. The smell and flies were only alleviated by a small fan in the corner of the room. In Hospital A, staff carried out their clinic consultations on Mondays (focused on new patient and special cases), Thursdays, and Fridays in two airconditioned rooms with multiple doors and a large waiting room area (not airconditioned) that shared with specialized clinics and outpatient services (cardiovascular, etc.).

Each clinic day typically began in a similar way. A patient first entered the clinic building and usually approached the nurses' desk to grab a number, although the order of first come, first serve was not always followed. Documentation of outpatient and clinic visits were recorded using two notebooks per patient. One notebook contained history (allergies and illnesses) and information about their diagnosis while the other booklet contained drug information such as past and current medicines and their dosages. After the patient took their number, they sat down in the waiting area. At Hospital B and C, they waited in the ward's tv watching area.

The amount of waiting time varied with the demands of each clinic day (i.e., the number of patients, availability of staff, etc.). The average waiting time for patients interviewed was 1.25 hours. While waiting, patients kept mostly to themselves, though sometimes I would see patients and family members talking with one another. As a strategy to avoid being associated with mental health services at Hospital A, some patients told me they prefer to sit on the benches associated with other clinics until their number is called. When patients entered their consultation room, they usually sat nearest to the doctor, while family members (if present) sat next to them.

If the patient was new, sometimes the doctor would clear the room of patients and nurses for privacy, or he or she may go with the patient to another room in the ward (depending on the hospital). From my observations, private conversions were difficult to come by. Patients were required to give the physicians some indication (i.e., overt expressions of suffering, whispering to the doctor) for a private consultation to take place during clinics. In addition to the demand of numerous patients accessing the clinic that day, and burden of rearranging of rooms (if

necessary), also contributed to the lack of conversion between the patient and doctor during clinic consultations.

Doctors would often greet patients and ask how they are doing. Sometimes they asked while reviewing clinic notebooks, EKG sheet, and similar. Patients responded to the doctor in various ways depending on their situation: they may talk for some time, or say very little, depending their emotional state at the time of the consultation. Depending on how they present side effects and other problems may require the doctor to write a referral to outpatient department (OPD) or another medical specialty. Many patients expressed appreciation of medical officers' ability to directly refer them to specialists or other clinics.

Discussions during clinic may be long or short, depending on hinging on if the patient is new, or if the clinic is a follow up for a returning patient. For those seeming to need more in-depth assessment, doctors inquired if the patient had any physical and social problems interacting with others, and if they were able to accomplish daily tasks. For example, a clinic doctor might ask patients to extend their hands to check for tremors or assess their vitals (e.g., measure blood pressure, weight, and breathing using a stethoscope. However, physical examinations of patients are very rare. Only when patients complain of aches or pains, physicians might briefly examine particular areas of the body. Near the end of the consultation, doctors filled out the patients' booklets and other forms told them about medications if needed, and scheduled their next clinic visit. After leaving the clinic, patients might go to the pharmacist or nurse to acquire any injections and/or medications.

The use of "ward" refers to a setting where admitted patients' behaviors and medications are monitored within mental health units at Hospital A, B, or C. All mental health wards were for short-term stays in order to address acute mental and emotional problems. As discussed last chapter, a long-term stay rehabilitation unit exists for patients with chronic illnesses, or those who cannot live with family members. This rehab center exists apart from all mental health units in the district. Ward interactions provide more controlled environments where doctors, nurses, and

attendance staff can administer daily medications and talk with patients and family members. For example, inpatient care is partly organized using a board that is posted for staff. Staff reference the board when they first arrive to mental health units in the morning or return from their lunch break. They frequently look at these boards which outlines: each day's number of counseling sessions, number of clinics, home visits, and similar (monthly details).

Discussed in-depth last chapter, the doctors and nurses monitor inpatients through "ward rounds." Ward rounds consist of physicians and staff walking around each patient area to individually talk with patients and family members about their progress and status. Ward rounds also sometimes involve meetings with patients and family members in consultation rooms or staff rooms (usually once or twice daily), sometimes with psychiatric staff members (occupational therapist, nurses, psychiatric social workers, and attendance staff), or just a medical officer assigned to the patient. In Hospital B's ward, Dr. Pradeep is the primary medical officer while Dr. Rita manages all of the ward patients in Hospital C.

Physicians and other staff use ward activities to fill out necessary paperwork about each inpatient, make changes to their medications, and eventually discharge them from the unit. There are always one or two nurses posted at the wards, while at least one doctor is usually there from 8 AM to 12 PM and 1 PM to 5 PM (unless they are carrying out clinics, counseling, and other duties). A doctor is also on-call if any problems arise throughout the night. The length of stay for most patients receiving acute treatment in the ward settings can vary from one day to one month, but the units typically discharged patients within two weeks. Apart from occupational therapy at Hospital A and B, and a common area television at Hospital B, there are very few activities available to keep patients occupied while inside the ward. I often saw patients and family members lounging outside of the ward on the concrete benches at Hospital A. Beside interactions with mental health staff and regular drug distribution, patients were mostly resigned to sleeping, eating, and chatting with family members and other patients during their stay in the ward.

I refer to "home visits" when mental health staff went to patients' households to assess their daily living situations. Those selected for home visits were usually patients who continued to have problems after being discharged from the ward, or, if the doctors held doubts about their stability and wellbeing at home. Though rare, they also conducted home visits with patients who failed to come to scheduled monthly clinics. Home visits were usually carried out by a psychiatric social worker (PSW), who traveled to patients' homes using a driver and vehicle from the regional district health authority (RDHS). When I observed these home visits, if the patient did not have a phone number listed, it was often a challenge to find them. We went through villages, towns, and neighborhoods asking people in the area if they knew of the patient. The occurrence of home visits and other activities outside of hospitals dwindled in recent years. Vehicles were reassigned to address other community-based health-related activities (e.g., dengue and malaria prevention programs). Two vehicles were previously allocated for mental health services in the district but were now controlled by the RDHS.

The redistribution of resources presented challenges for staff who needed to travel long distances to rural areas for home visits and to facilitate other "outside" programs (e.g., group-based therapies, school-based programs). Based on my ethnographic research, multidisciplinary teams with PSWs were not able to perform their duties mainly centered on conducting home- and community-based activities to ensure drug compliance, provide counseling, and support outpatients by linking them to state-run welfare organizations or channels via the district or divisional secretariat (DS office). Service referrals help those eligible to navigate socioeconomic resources of support for patients living in poverty or without social support. Once paperwork is filed, and counselors are informed, the DS office may go to the patient's house to provide housing support for marginalized families or people living with disabilities. The scarcity of social welfare makes political negotiations necessary in order to obtain resources (housing, etc.); limited amounts of community services are politicalized, and one needs to know how to navigate local

leaders and authority channels to receive aid. In general, there are very few psychosocial resources available to address patients' problems and distress outside of clinic spaces.

For patients needing therapy beyond medications, physicians or PSWs refer them to a counselor in the DS office, or they carry out counseling services themselves. A problem-solving approach is usually the preferred method among staff. Based on my observations, a large percentage of patients utilizing counseling are people who attempted suicide. In my numerous observations of counseling services for attempted suicide cases, doctors, PSWs, or nurses ask about what happened and try to find the root causes for suicidal acts and overall distress. Physicians may also give homework to patients as part of therapy while multidisciplinary teams help to address the patients' other socioeconomic problems. If their care manager is a medical officer or a consultant psychiatrist, they may carry out psychotherapy - usually cognitive behavioral therapy (CBT), and Dr. Pradeep is also trained in mindfulness therapy and yoga. I observed each of the medical officers at some point teaching patients breathing exercises to help alleviate their tension or anxiety.

Clinics at Hospital B

The mental health unit is slightly separated and in the back of Hospital B. The building is surrounded by banana trees, part of a small income generation project associated with patients staying at the ward. As part of occupational-like therapy, patients sometimes pluck bananas and maintain the trees in the garden. The attendance staff would sometimes bring in a buddle of bananas for us to eat, with afternoon tea midway through clinic consultations. Dr. Pradeep would say with delight, "you take, it's from the garden." During one of our interviews, I asked him about the role of family members in providing care for a particular patient and he brought up occupation-related projects in the ward:

> He neglected the daily activities, he neglected himself of his personal care and other things. He neglected the food and other things; he neglected the work and then the family. But slowly now, he improved the skills. That we allowed the space, now he is much socialized. He watches entertainment, he watches television and other things. He started work…one component is in the garden, pouring water…and another component,

> cleaning their beds and making the beds clean. And cleaning the toilets. Cleaning the rest of their room and other things…So those are the soft skills. You know with schizophrenia, for many years, the patient has lost the soft skills…we restarted the soft skill. And then the family member is observing them…earlier they resisted to eat, now they are much happy and want to be doing it. It is part of symptom control without medicine…. And we also educate the family members about the pill, the frequency, and the dosage. Sometimes the side effects. Then it is easy to control that patient…Then the family member have the guts and also some more influence…now patient is recovered and now he has job opportunity…his is sleeping well…that's enough for us. You know that the clinic is only the continuation.

Dr. Pradeep suggested his approach went beyond symptom control through facilitating "soft skills" that are an important part of the recovery of the patient. He also notes educating family members about the treatment process helps "control" the patient for "symptom control without medicine." Next to the mental health unit is a water fountain and a newly built stroke and rehabilitation unit. Dr. Pradeep sometimes used the stroke unit—which has private rooms—to house clients who did feel comfortable in ward settings (6 beds to a room, etc.) within each mental health unit. Following a similar path to Dr. Ramesh since arriving in Batticaloa, Dr. Pradeep sought additional funds from NGOs to build facilities and fund other programs for patients to access mental health services. For instance, during my research, he worked with an international Christian NGO to set up a school for youth with autism.

Clinic days on Mondays and Thursdays at Hospital B were sometimes hectic with as much 50 or more patients (with family members) waiting to be seen by Dr. Pradeep. People lined up against a wall that stretched from the consultation office to the male dormitory and TV room. The same long queues also be seen on clinic days in both Hospital A and C. When Dr. Pradeep arrived at the mental health unit, he usually greeted the nurses and attendant staff in the staff meeting area, and then walked down the line of patients towards his office. Once seated at his desk, he was usually handed a stack of inpatient folders. After the door to his office opened, a stream of outpatients and family members would come piling in.

Demanding patient loads, meant little time for dialogue between doctors and patients in clinic interactions. It was common practice to keep clinic consultations simple unless the patient

displayed obvious, overt problems. Most people were returning patients to simply pick up their medication(s). Expediency was also required since Dr. Pradeep needed to finish consultations before the pharmacy in the ward closed in the afternoon. After, the pharmacist moved to the main pharmacy at Hospital B. This schedule was also true for Dr. Rita at Hospital C. As Dr. Pradeep described, "That's the way because otherwise, if you go for detail everything, it is very difficult to see nearly sixty patients within a particular time. Because the pharmacy closes at 12:00; it opens for the rest of clinics." Thus, it was common for consultation interactions in all hospitals to take less than one or two minutes, with such questions as, "hello, how are you? Any problems? What are your thoughts? Do you have an appetite?" Patients taking certain anti-psychotic medications needed other checks-up due to how the drugs affect their cardiovascular and other bodily systems. Check-ups may not be necessary with anti-anxiety or anti-depression drugs. The doctor took blood pressure, checked other vital signs, ran blood work (the drugs raise cholesterol levels), checked paperwork (electrocardiograms), as well as referred patients to other medical specialties (neurology, cardiology). Both patients and doctors learned how to exist amidst these bureaucratic routines of clinic visits, but medical officers formulated personalized strategies that demonstrated conflicts, contradictions, or tensions within performing these routines.

On one morning in June 2017, Dr. Pradeep had a large amount of clinic outpatients; I counted more than 70. Amidst the routine of clinic consultations, Dr. Pradeep would notice a new or returning patient who seemed really upset (more than normal). He would then have all the people (patients and staff, sometimes a nurse would stay) leave the room. I would usually say, "should I leave?" He would say in relaxed manner, "No, you can stay." I would then look at the patient and say (in Tamil), "If I stay, it is okay?" No one ever said no, but there are issues with this power dynamic, i.e., the powerful doctor approves me before the patient, so they must comply; or they felt pressure to allow a foreign researcher to listen to her conversation with the doctor. Dr. Pradeep swiveled his chair in their direction, at the side of his desk, and rolled his chair closer to them. He leaned forward and stared deeply into their eyes. Though Dr. Pradeep is

of average height, he has a big upper torso and large hands that can have a powerful effect on the people he meets. When I first saw this, I thought he was putting on a bit of show for me. However, I saw him do this with many other patients subsequently.

On this day, an outpatient in her twenties came and sat down. She was on the verge of crying in front of Dr. Pradeep. Throughout the day, there was steady movement of patients, family members, and nurses around the consultation room, as well as those standing outside the office door looking in, waiting for their turn to see the doctor. After seeing almost sixty patients, he tiredly looked at her, not noticing her distress, and asked, "any problems? She began to cry a little. After this reaction from the woman, and what he might remember about her (as a returning patient) and her diagnosis (in her booklet), he decided it was necessary to give her privacy to talk. After the room cleared, he waited until she was ready to talk and asked, "what's the problem?" When Dr. Pradeep leaned forward to engage in what she was saying, she looked away and then looked back again at the doctor. She outlined her difficulties to Dr. Pradeep. She had five daughters, and all were not attending school. Her husband disappeared during the war and she had numerous stressors raising her daughters. He had diagnosed her with depression and prescribed her anti-depressants. Dr. Pradeep stared intensely as she finished explaining her socioeconomic struggles as a single woman raising children in post-war eastern Sri Lanka.

Her narrative was not uncommon and presented complex similarities between other patients I interviewed or observed in doctor-patient consultations at mental health units. This interaction did not last more than 10 minutes. Beyond referrals to the DS office (which he had already done) and other services (e.g., PSWs), there was little Dr. Pradeep could do to help her besides listen to her for a moment, provide reassurance, and give her a few hundred rupees of his own money for help. She thanked him and walked out of the room looking slightly defeated. Moreover, even if he had scheduled psychotherapy (CBT, etc.), like some other clients, it was unlikely she would have the time and money to come (beyond clinic visit for medications) given

her work, household duties, and parental responsibilities. In Chapter 6, I discuss health-seeking narratives and socioeconomic stressors among women headed households.

The woman's testimony provides an example of the difficulties for woman-headed households and others affected by the civil war, people who would likely benefit from outpatient services beyond medications. This interaction highlighted Dr. Pradeep's personalized strategies that allowed him to break from bureaucratic and medicalized routines (if only briefly) and discuss larger issues beyond symptom management with patients. Like Dr. Ramesh and other medical officers from the east, Dr. Pradeep aimed to mitigate bureaucracy and hierarchy through less formal and more personable approach to patient consultations. As he described:

> Here we want to step down and we are not hierarchy of I'm a consultant, or I'm senior man, just we are moving very simply. As a result, our, you know the dress and everything…like we are respectable. If we are very simple, the patient also moves us. He wants more friendly. It depends on one, sometimes we take this patient in one session or the second session, huh? And they also have a good space to share something with us, so I ask do you want to talk alone? I want the privacy…So, then the rapport or the transparency, much rooted which help the client, is due to good history. Or they can come up with like with the patients have the problem with homosexual thoughts, but he couldn't open. He opens now, open wound now. The abscess has collected is a very terrible thing. Once you open, just you put a nick it is enough. Everything come out, your pain is out, the wound is healed. Likewise, here the trauma which collects like abscess, once we open, it drains automatically…

Even though Dr. Pradeep used personalized strategies to help fill gaps in psychiatric services, it is hard not to notice the difficulties in making such gestures when one doctor and a few staff members (nurses are sometimes shifted to other wards and clinics) have to provide services for 30 or more patients in one day, all with a variety of needs and treatments that may or may not be addressed given the limitations of medicalized approaches and availability of state social welfare (support outside the hospital). These constraints limited opportunities for clients to have extended periods of time to talk with medical officers—let alone the consultant psychiatrist who is stretched thin while managing district-wide mental health services.

During my ethnographic research in hospital environments, I observed numerous forms of mental and emotional distress exhibited by patients. A vast majority of clients came to

hospitals with complaints related to sleeplessness (*thuukkam illa*), worry/anxiety (*kavalai*), fear *(payam*), headache (*thalai vali*), depression/sadness (*thukkam*), no hunger/appetite (*paci illa*), and thinking too much (*yoocinai varum*). As Dr. Pradeep described,

> For the ex-patients, they are coming multiple visits, then our basic questions about the daily living. Not about the biological sleep, or an appetite, then their self-care…I have seen the patient for the last four years. Then I know much about the patients…always complaining, medically unexplained. They are mainly focused on mental…The common ache and pain...especially the Sri Lankans; they want the medicine, from head to toe (laugh)…

It is sometimes difficult to interpret if these expressions of suffering are the result of side effects of drugs, or are physical manifestation of continuing problems going on in their life. According to physicians I spoke to within mental health units, psychosocial determinants of distress were addressed in a secondary manner in mental health units, while risk/stability, family management, and drug compliance were the primary concerns of their medicalized routine.

Bureaucratic and Medicalized Routines of Doctor-Patient Consultations

Ethnographic observations of doctor-patient interactions and interviews with staff document ways new and returning patients were managed in historically rooted medicalized knowledge and practices that are generally followed among psychiatric and mental health physicians. As discussed in the data, cultural models of care for mental health units in Batticaloa follow a bureaucratic formula, a mixture of global, national, and local techniques for psychiatric and mental health problems (i.e., the Angoda model, friendly services and recent local models of psychiatric care). In order to obtain a diagnosis and develop a treatment plan for patients, there is a series of information must be collected and assessed during medical consultations.

For new patients in "ideal" consultations, doctors would collect and document the following: 1) general information (e.g., age, name, family status), 2) medical history and complaints (i.e., why they are at mental health unit), 3) statements from family members, 4) vitals and physical exam (if not already carried out), 5) mental state examination, 6) diagnosis, and 7) treatment plan. I observed hundreds of these consultations with different doctors, and witnessed a

multitude of ways doctor-patient interactions were centered around the bureaucratic and medicalized routines of treating severe mental disorders (those considered most high risk and vulnerable). Through this medicalized and bureaucratic practice, physicians decided whether to admit a patient into the ward or start them on monthly clinics.

Socioeconomic determinants of distress tend to be ignored or mystified within bureaucratic, medical discourses and practices. My data shows that socioeconomic factors of distress were mostly addressed by physician personalized strategies that went beyond symptom control and patient referrals to counselors (within the hospital or at the DS office). I document how idioms of distress are mystified and reworked through medical procedures in a manner that distances patients' distress from its social origins. With the Angoda cultural model of care and Dr. Ramesh's approach, there has been a focus on severe mental disorders that have primarily driven narratives and approaches to mental healthcare. That is, mental illness and mental disorders are homogenized and condensed to extreme forms of mental illness.

Risk and Stability

In mental health units, physicians usually assess first whether a patient is at risk to others or themselves. Doctor-patient consultations are obviously different if it is a new or returning patient. When patients first come to the mental health units at either Hospital A, B, and C, doctors usually observe the stability of patients' emotions and symptoms. Sometimes police officers, counselors, or family members bring patients once they have reached a breaking point or boundary of some kind that suggests patients are having or causing social and moral disruptions (e.g., bothering neighbors, suicide attempt). For patients who exhibit suicidal, disruptive, aggressive, or violent behaviors, they often sedate them patients and typically admit them to the medical ward. Without looking at paperwork or hearing patient dialogue, I usually recognized a person who had attempted suicide because of an IV in their arm. Once patients were sedated and given sleeping aids (if necessary), the doctor usually conducted a more thorough analysis to obtain a diagnosis and form a treatment plan. It is important to mention that most initial patients

were given sleeping aids for their first month. Physicians typically do not usually prescribe sleeping aids for more than a month due to fears of patients developing dependency issues. If patients are relatively stable, physicians and staff follow typical patterns of diagnosing and treating patients.

Some patients referred to the mental health units come in with substance abuse issues or alcoholism. Such patients should first be treated in the medical ward, under close supervision as patients experience withdrawal symptoms and other issues. Dr. George described the dangers of admitting patients with alcohol issues, "they come as psychiatric patients for us because nobody diagnosed before. They send them as a psychiatric patient, and they stay one or two days in the psychiatry ward; it will be permanent damage on the brain or another thing. So, we have to exclude these emergency things. That's different." For all other cases, he described the process, "For such emergency, we usually give something sedative for sleep and all these things first…Yeah. We usually put them if homicidal, suicidal, self-harm, or something, because we put them in the ward and even if they don't have insight of their illness, usually they tend to keep them in the ward. Otherwise, they won't take the medication."

Admission to mental health wards is voluntary. Special documents are needed from district courts, family members, and probation officers (who manage youth cases) to hold violent or aggressive patients against their will in the "secure room" at Hospital A, a small room with a prison-style metal bar door that prevents the patient from escaping. I rarely saw patients in this room given that most patients considered out of control were usually sedated with drugs. On one occasion, I remember an older woman in her sixties was put into this room because was she playing with her feces, which appalled and disgusted the attendant staff who had to clean it up.

Emotional extremes are constantly seen at clinic and become normalized in mental health units. I observed how empathy among staff could deteriorate with large numbers of patient and the routines of patient interaction. In clinic and ward consultations, with new or returning patients, I noted at least one patient or family member breakdown. Finding it difficult to manage

the extremes of emotions, a patient may pace inside the consultation room then leave, come back, and interrupt a consultation with another patient. If a patient is having a manic episode, for example, they may break down during an interaction with the doctor. Thus, medicalized practices in Batticaloa District and elsewhere in Sri Lanka are structured around caring for serious forms of mental illness, which has contributed to a lack of development of outpatient services and of doctor-patient relationships.

Diagnosis, Documentation, and Technology

One feature prominent among all formalized medical consultations is the diagnosis. Every physician I interviewed said they primarily used the ICD-10 to diagnosis patients. In contrast, the former consultant psychiatrist, Dr. Ramesh, described problems and difficulties with diagnosing in psychiatry, and what he termed "syndromal definitions of disease":

> …loosely, I use the ICD-10. But I am not very obsessed about it, or, because, you see in mental health, we still use what we call syndromal definition of disease….it's just a collection of difference in terms which occur more than by chance, together…a very imprecise way of defining a disease…homosexuality was a disease, and then, suddenly it became a non-disease. Right? So, the influence of society, culture, all that becomes very important because of this kind of looseness of the syndromal definition process…Depending on the political winds, not necessary based on science though, right? …can narrow down the diagnostic criteria, you can loosen it up…we tend to forget that. So, I would be very careful about labeling. And also with clients, I would prefer to describe the problem they have rather than put a label…for example, very rarely you would have used schizophrenia per say. I would say…you are not sleeping properly, your brain is working too much, it is interpreting things in the wrong way, and kind of describe the symptoms together. Rather than, like, you know, pin a diagnosis. I would have working diagnosis, but not necessarily always share with it. …I always work on diagnosis. Because…we start treating patients symptomatically, and that's not good. Somebody has headache, has any depression, or whatever…it becomes the diagnosis, the diagnosis becomes too over inclusive…So, we do write the diagnosis, but though the system doesn't really, really require it, which is a good thing. Um, but if the patient specifically asks, "Doc, I need to have a name for the problem I have." Yes, then I would, but I would tell the diagnosis with a lot of warnings, like, "look, be careful what you google, when you google schizophrenia or depression, you are going to be find all sorts of odd things. Please come and ask me," …There are patients who will kind of insist on having a label…But, unfortunately, the labels in mental health, carry a lot of stigma. Self-stigma…But, we don't look at it like word-to-word, "what does it say here," we don't go like that. That, that applies to most psychiatrist in Sri Lanka, we wouldn't go like, word-to-word…

Most physicians in Batticaloa (and elsewhere in Sri Lanka) are not regularly using the Diagnostic and Statistical Manual (DSM). Allopathic doctor informants suggested they only referenced it for research purposes or for diagnosing and treating stress-related problems. Doctors suggested the ICD provided more flexibility than the DSM in diagnosing patients, with most Sri Lankan doctors trained to use the ICD.

To consistently monitor patients and recognize any changes to their conditions, Dr. Chamil at Hospital A focused his efforts on improving documentation and assessments of patients by mental health staff. A major part of diagnosis is thoroughly documenting complaints from patients. Dr. Chamil expressed the importance of documentation to ensure the correct diagnosis and treatments for patients. He stated:

> …we see there is no diagnosis only the drugs, so we don't know why they have started…it's good to have a diagnosis for future references, so it gives some direction…but again, in psychiatry I think one of the most important things is to be very flexible. To see whether earlier diagnosis is correct…once again, it depends on the documentation. The documentation is correct then maybe around 5%, a lack of documentation then the chances will be a bit higher. Then roughly around 40%...This why the documentation is necessary because mainly the diagnosis…symptoms are decreasing is important…those things into documentation...

Beyond formal documentation of patient's diagnosis and treatment, doctors do not typically discuss diagnoses with patients unless it may be useful to produce action. They also do not tell the patient about all of the possible side effects for fear they may come to clinic consultations complaining about these issues. Thus, they keep their description of side effects to a minimum. For example, if the patient is a tremendous burden for the family members, the doctor will use "mental disease" (mana nooy, I never heard them use the term crazy or "paittiyam") in order to justify patients' abnormal or abrasive behaviors (i.e., by saying "it is not their fault," attempt to displace negative opinions of patients' behaviors). This technique displaced some of the blame from the patient. If they present with minor issues, the doctors will adamantly tell them they do not have a mental illness, "don't worry" (*kavalai illa*) and "it is no problem."

In general, most physicians I spoke to did not refer to the ICD often and mostly relied on experience and memory to diagnosis and treat patients. They mainly used the ICD for complicated cases where patients had not seen improvements. Despite common problems of cross-cultural applicability of diagnoses (for "psychiatric conditions"), most physicians expressed confidence in the process of diagnosing patients. As Dr. Kanayama described:

> It is the symptoms…The ICD 10…That depends on how severe the patient's symptoms, how organized the symptoms are. Say they are full blown; it is easy for us then. If they are lasting for more than one month or so. It is easy for us to control diagnosis…home remedies, religious rituals, if they take some time, the symptoms are now full blown…schizophrenia is very high…it is easy for us to come to a diagnosis…

Based on observations, regular cell phone use is common with all types of social interactions at mental health units. Doctors use cell phones to contact patients and family members when needed. For example, if the patient came alone to the clinic, the doctor might call to get a hold of the family member to discuss certain issues. The phone is also used to check diagnostic manuals (ICD)—available online—if they felt had ambiguity when diagnosing or treating a particular patient. I also observed nurses and MOs regularly contact Dr. Chamil via cellphone when they were ready for him to review patients at Hospital A. He would also give permission to use certain drugs and dosages or provide advice to MOs who were having challenges treating patients. Staff also used their phones to transfer patients to different wards or the long-term rehab unit. At one point a person came into the ward and showed an MO a video on their phone of a patient with a cough. One day, during consultations, at Hospital B, I observed a patient and his family members give Dr. Pradeep a cellphone as a gift for his help in managing his medications and other issues while he worked abroad in the Middle East.

Family Management

The role of family members in caring for patients and ensuring they maintain drug compliance is a major part of mental health services in Batticaloa District. A common belief among mental health staff is patients will relapse and resort back to "risky" or unstable behaviors and would need to be stabilized again. Still, psychiatric services and biomedicine are theoretically

individualized. As discussed in Chapter 2, and Chapter 6 in relation to health-seeking strategies, the role of family is highly connected to a person's mental and emotional distress, or wellbeing, in South Asian and Tamil cultural contexts. This role is even more pronounced in Batticaloa District's mental health units, and bureaucratic routines within doctor-patient consultations. An example of institutional reliance on family labor, based on the mental health policy in the district, includes the requirement for a "bystander," or a family member to stay in the ward besides the patient if they are to be admitted to mental health units. This policy ensures that both patients and family members go through an education process about psychiatry and its treatment, in which the families learn the procedures of taking drugs and managing symptoms in order to maintain drug compliance, especially for patients dealing with severe psychiatric problems.

If there is a fear of relapse for patients, the patient's authority and self-responsibility for improvement is displaced to the family members through education about the patient's illness and drug compliance. Medical authority is transferred from doctors to family members who become decentralized monitors of patients. Through this education process, signs related to selfhood, status, and suffering are manipulated by medical establishments. In deploying family members, physician informants suggested patients were less likely to relapse (to former behaviors or symptoms) and more likely to attend clinics regularly. Dr. Kanayama described how family members were crucial to mental healthcare:

> So, I always rely on the family members. To continue with the support…the nurses and doctors will look after the patients with medication at least. The time of day they will get the treatment. But once discharged, the same thing should be continued. For that, the family members should get the training, that's the reason mostly, we ask the family members to stay next to the patient. Then they will get the training, this time we must give the patient these medications…Mostly that's all.

People working in mental health services generally want to maintain stability of the patient through educating the family members about controlling symptoms with medications and maintaining drug compliance. Such cultural models of care decentralize and displace medical

authority to family members. Medical officers were adamant about the importance of family members in successful treatments. As Dr. George describes:

> Yeah, because usually their relationship breaks down…It is important for the relatives to come and we usually talk with the relatives mostly, because they should be the one who should understand about the illness. Because if you give medications, we don't have to educate the patients…they will act normally in two or three weeks. But the relatives are the most hurt ones…it's been difficult to, um, educate the caregivers. The patients are easy; the caregivers, they try to leave them in the ward or divorce from them. Otherwise, the children will try to chase them away. That's been a very difficult job, most of the time…Drug compliance, yeah, usually most of them will stop within one month. Then after the second or third visit, they will start to give the medications regularly. Even if you send a lot of time with the family members, they usually don't care about the continuation of the medication. They think they are cured. So, they will stop the medications.

Within these medicalized routines, family members are not utilized in mental health services in a way that builds on recovery-based approaches to treating mental illness and emotional distress. Instead, such routines structure relationships between doctors, family members, and patients around drug compliance.

Conclusion

In this chapter, I argued that current mental health practices have contributed to a deskilling of medical officers who possess influence and vast local knowledge and understandings to help patients manage their socioeconomic problems beyond medications. Current medicalized knowledge and practice devalue medical officers' capability to utilize local understandings of patients and develop strong therapeutic relationships with them. First, I analyzed literature and studies concerning the anthropology of doctor-patient consultation, particularly within bureaucratic and medicalized environments. Such studies illuminate the ways routines in doctor-patient interactions may reinforce larger socioeconomic ideologies and inequalities. Second, I discussed broader socioeconomic changes and political challenges among both doctors and patients living in the east, and how medical officers fashion themselves according to different narratives and symbols of mental healthcare in Sri Lanka (e.g., regional

differences, Dr. Ramesh's approach, etc.). Third, I outlined four main types of social interactions in which physicians/staff interact with patients: ward, clinics, home-based, and counseling.

Fourth, I presented ethnographic evidence from Hospital B, to illuminate bureaucratic features and personalized strategies used by Dr. Pradeep during doctor-patient consultations. Amidst these clinic routines, patients must show extreme emotions to receive attention from Dr. Pradeep. Though he possesses great skills that would allow him address many of his patients' psychosocial determinants of distress. With bureaucratic routines and the demands of numerous patients, he is unable to address stressors through in-depth discussions and building therapeutic relationships with them (i.e., allowing patients to talk about their life and social problems that goes beyond medications). Fifth, I discussed key medical and bureaucratic routines structuring social interactions and therapeutic relationships between doctors and patients around drug management of symptoms and drug compliance. Specifically, I analyzed risk and stability, documentation and technology, and family management. In the district's mental health units, these medicalized practices were important to reviewing and monitoring patients. Compounded with limited resources, such practices threaten to deskill medical officers and fracture therapeutic relationships between patients and doctors that could better address social determinants of distress.

In the next chapter, I analyze health-seeking narratives highlighting patients' personalized strategies to manage their distress. They interact with a variety of healthcare providers, but ultimately chose state-run mental health services in Batticaloa District. Though patients had personalized strategies and routes to alleviate their distress, I illuminate shared challenges and struggles that extend beyond the reach of pharmaceutical care.

Chapter 6: Health-Seeking Narratives: Clients' Socioeconomic Stressors and Personalized Strategies for Managing Distress

In this chapter, I employ a qualitative analysis of four patient histories and their strategies to alleviate mental and emotional distress. I supplement these narratives using data from other patient interviews in order to document commonalities between identities, health-seeking narratives, and socioeconomic stressors. These ethnographic narratives illuminate meaning-making acts involved when deciding on mental or emotional healthcare options, common vulnerabilities and characteristics of outpatient groups, and the limitations within current medicalized and bureaucratic approaches to managing distress in the east.

As discussed last chapter, medicalized and bureaucratic routines in mental health services present serious limitations to mental health support beyond drug therapy and compliance. My interviews with 23 clients contain a range of sociocultural and political processes that influenced their access to state-run mental health services and other forms of healthcare. This ethnographic research documents health-seeking routes taken to manage mental and emotional distress as tied to clients' identities (class, caste, religion, ethnicity, gender, and age), histories, family relations, supernatural forces, and socioeconomic changes. Amidst different individualized and personalized strategies for alleviating distress, I argue that there are common idioms of distress and sociocultural determinants within clients' health-seeking narratives.

This study investigated clients' strategic healthcare decisions among local pluralistic therapies and sociocultural factors correlated with their expressions of distress. In this chapter, I describe health-seeking narratives for mental and emotional distress that are analyzed according to gender, transnational labor, external supernatural forces, sexuality, and poverty. These narratives highlight diverse routes patients take to manage their distress, as well as the benefits and drawbacks of mental health services in Batticaloa District, particularly regarding outpatient services. I focus on these themes for the sake of space and relevance to earlier chapters regarding local understandings of mental and emotional distress, contradictions in belief systems and the

history of mental health services in Sri Lanka ("the Angoda Model"), and recent developments in mental healthcare in Batticaloa (from "Friendly Services" to a decentralization and displacement of authority onto family members for drug compliance). Patients developed personalized strategies to associate and interact with mental health units, and an ethnographic focus on these negotiations captures ways patients accept or avoid labels and their continued use of biomedical services. Finally, health-seeking narratives may have practical value in illuminating sets of vulnerabilities and marginality among patients, and in designing or developing outpatient mental health interventions and services (e.g., group therapy) in Batticaloa District and elsewhere.

Women Headed Households

Though I did not ethnographically observe clients' daily living outside of hospitals, Nasrudeen and I interviewed most people in their homes. During interviews, and joining psychiatric social workers for home visits, I observed their living conditions, met family members, and drank tea or ate snacks offered to us. We first met Padmadevi, a Hindu woman in her forties, while she was living at home with her two children and father. She studied up to Grade 9 and did not have paid employment. She mostly received money from her family members (brothers, sister, and parents) who gave her contributions periodically. We talked on a shaded porch area outside her three-roomed medium-sized home and small garden. Her yard was surrounded by a fence and bushes that somewhat shielded the views of neighbors, vehicles, and others passing by on the busy road.

As the civil war was ending in Sri Lanka, Padmadevi's husband was kidnapped by a squad of troops. She did not know if it was LTTE or government forces, but described when the white van—a powerful symbol of terror in Sri Lanka, special units that kidnapped people off street corners and other location—came to her home and soldiers took her husband away. She suggested people may have had ill feelings toward her husband because he aggressively collected money for his job at a jewelry shop and would sometimes intimidate people who owed money to the shop. Due to the nature of his work, Padmadevi believes that someone wanted him dead and

told local military forces that her husband was an LTTE fighter, leading to his abduction. She screamed and shouted at others to help her husband during the abduction. One of the men hit her with his gun, leaving a scare on her head. They also hit her in the mouth, breaking some of her teeth. Her nine-year-old son was also beaten. After this terrible incident, she was overcome with sadness and grief (*thukkam*), overthinking (*yoocinai*), had no appetite (*paci illa*), ignored her self-care, lacked sleep (*thuukkam illa*), and had numbness on her head (*maraththa thalai*). She also had low energy (*sakthi illa*) and stopped engaging in social and household activities such as playing with her children, going to temple, and sweeping or cooking. She laid in the corner of the room and cried most days.

Given her condition, and local and South Asian ideas about mental illness as discussed in Chapter 2, her parents first consulted neighbors. They said her daughter had been possessed by an evil spirit (*peey*) and needed to be taken to a Hindu priest (*pucari*) working at a goddess (*amman*) temple (*kovil*). Katharina Thurnheer's (2014) ethnographic research on 2004 tsunami survivors living in eastern Sri Lanka illuminates narratives of survivors who actively resist being associated with local notions of madness (*paittiyam*) and highlights fears and stigma associated with mental health services. As Thurnheer (2014, 246) describes, "Actively seeking help from the mental health sector, in any case was a step rarely taken. It seems that seeking psychiatric help invited social stigma to a degree that was not the case when paittiyam remained within the framework of local, ritual practice."

When Padmadevi arrived at the temple she was shouting and crying, so the priest locked her in a room chained to the wall, where she was not given food nor water. She recalled the priest frequently blowing a white powder in her nose to get her to sleep. He also beat her with a whip to remove the evil spirit that affected her body. After almost two weeks, her husband's mother came to visit her at the temple and observed her condition had worsened and she was in a semiconscious state. Her mother-in-law told her parents about her condition and she was taken to a neighboring district hospital. She was admitted for a week and treated by Dr. Arthi. According

to Padmadevi, Dr. Arthi told her that her illness developed from the kidnapping of her husband and possibly from being hit on the head with a gun.

After she was discharged, Padmadevi followed the monthly clinic for two years. At one point, she stopped taking her medications all together and wanted to use only religious devotion to manage her distress. After three years of using no medications, she suffered a relapse during a temple festival, became unstable (screaming and shouting), and her family took her to Hospital A where she was placed in the secure room at the ward. After this incident, she began retaking medications and accessing outpatient clinics. At the time of our interview, she met with Dr. Viji at a hospital closer to her home. These treatments allowed her to manage her distress and accomplish daily household tasks. She said, "before I cannot do the household work and properly look at my children, now I am able to do these things."

On a separate occasion, Nasrudeen and I took a break from our long life history interview with Padmadevi. We walked over to a shop nearby and bought flavored milk boxes. As I walked around the corner sipping on my milk Nasrudeen walked away from the shop as another man approached. With his eyes on us, eh asked the shop keeper and asked, "what are they doing?" The shop keeper responded, "they are talking to that lady," and gestured towards her house, "I don't know why. She is crazy (*paittiyam*)."

Padmadevi was well aware of the gossip surrounding her life situation. She shared, "They are saying I am affected by mental illness. They say, 'You are crazy.' It makes me feel sad." During our interview, we asked her what qualities make a person have a healthy mind and body, and she quickly brought up the issue of gossip. As she described,

> Gossiping in the community is the biggest issue. It affects a person's mind. Without a husband, the people around me are gossiping. They are saying, "she does not have a husband, but she is wearing the *pottu* and colorful dresses." They are making up stories, especially young women living without husbands.

Padmadevi's situation is both similar and different to other clients I interviewed with mental and emotional distress. Her situation contains both individualistic and collective qualities of suffering

in post-war conditions in the east. This complicated health-seeking narrative and experiences of kidnapping and loss was unfortunately common in the war-torn east. Padmadevi had personal experiences with local gossip and labels regarding the ambiguous social status assigned as both a widow and mentally ill person. Asked how her life would be different if she was not managing mental and emotional distress, she said:

> If my husband was not kidnapped by the troops, my life would be completely different. I can live a happy life with my husband and two children. So, now the people are gossiping about me because I do not have a husband…My neighbors are making up stories.

Aangela is a Roman Catholic woman in her fifties with three daughters and one son. She studied up to O-level and her husband is a fisherman who suffers from alcoholism. She separated from him 16 years ago and she worked for numerous years to support her family. Along with assistance from family members, she earned money at a local training agency doing custodial work such as washing sheets and cleaning rooms. She found the hours and work difficult. Before she left, and after she returned home from work, As a single mother, Aangela had to complete household duties before and after work, and she found both hours and work difficult. She struggled to save enough money to ensure both her daughters have houses once they marry – an important part of matrilineal kinship that demonstrates (to your neighbors, extended family members, and other social observers) you are fulfilling your duties as a parent. She also highly worried about her drunkard husband, who gave her thoughtfulness and sleeping disturbance. All these factors compounded into a moment at work where she started to have shortness of breath and fainted.

Coworkers took her to Hospital A where she was treated. Her older sister ultimately decided the family should speak to a psychiatrist. After meeting with Dr. Chamil and Dr. Kanayama a few times over two weeks, to prescribe the correct drug and dosage, she began attending monthly clinics. She stopped working as a custodian at the training institute and earns small amounts of income from weaving basket. Like Padmadevi, Aangela's narrative includes the

difficulties and pressures of being a single mother in eastern Sri Lanka. Not only due to economic and financial constraints, but also in relation to social roles in one's family and community.

Rumaisiya is a Muslim woman in her forties who lives with her mother, two elder daughters, and son. Although her husband died of a heart attack at the young age of 40, she insisted that her "mental problems" started until the death of her husband's mother and mother's sister. She started to develop repeated thoughts of her older sister, which gave her lots of fear. This fear led to breathing palpitations, a lack of appetite and sleep, tremors, and dizziness. She told her younger sister about her ailments, and her sister shared similar problems and sought treatment from Dr. Rita at Hospital C. Having a family connection, she went directly to the mental health unit at Hospital C.

The three health-seeking narratives discussed in this section exhibited similarities in regards women's experiences of managing their household without their husband. They navigated different statuses associated with local and South Asian understandings of widowhood, divorce, and mental illness (paittiyam, mana nooy). Though Padmadevi, Aangela, and Rumaisiya were of different religions and backgrounds, they share vulnerabilities and qualities linked to mental and emotional distress, and their narratives highlight similarities in social determinants of distress and stressors associated with women headed households. The current findings build on existing ethnographic and qualitative studies related to widowhood, single women, and women headed households in Sri Lanka, India, and Tamil-speaking communities (Derges 2013; Lamb 2000, 2001; Hyndman 2011; Hyndman and De Alwis 2004; Thurnheer 2014). This area of research illuminates ways war destabilizes gender and other social relations, and creates a range of stressors, gossip, and social ostracism.

Transnational Labor Households

Afra's house is located within a semi-urban area, down a narrow road leading to numerous gates and homes. Such densely compacted homes, delineated only by a narrow wall, are a common sight in Muslim areas in the east. I remember starring out from a roof in her town. I

saw house after house (some bigger than others) neatly packed in and around roads connected by smaller lanes. Cement blocks connected to metal gate that shielded Afra's home from her small neighborhood cul-de-sac. Her house was small and limited space divided her house and the outside walls. In this small, shaded space, she planted small trees and various plants and flowers. This fixture of plants lined the small entry way to her home. At the time of our interview, Afra, a Muslim woman in her thirties, lived at home with her husband, daughter, son, and mother-in-law. Her husband worked as a sales representative in the Middle East making around 18,000-20,000 LKR per month. Similar to her father, who worked as a handloomer, Afra and her husband only studied up to Grade 4, and her mother had no formal education.

Afra started having problems following her husband employment abroad and the death of her father. She grew up in house with only two room that contained only two chairs and no other furniture. She mostly remembered her mother scolding her and withholding love and affection. She described feeling shame that her parents fought constantly, and she described an incident where a neighbor came up to her and asked, "why do your parents fight all the time?" She felt ashamed of the fighting.

When Afra was an adolescent, her mother went to the Middle East to work as a housekeeper. During this period, she and her younger brother were mostly raised by their father, yet given she is 10 years older than her brother, Afra spent much of her adolescence taking care of him. She held a lot of contempt for her mother and felt their family had no unity. As a child, she did not really see extended relatives like aunts and uncles, and the family did not get together for festivals or other traditions. Both her mother and father were absent during her menstruation a culturally and personally significant milestone, so she had to ask friends about the things happening to her body and what are the local rituals surrounding her progression into womanhood.

In adulthood, Afra broke with tradition and began avoiding her mother by living in a separate residence. She noted going through conflict intermittently with her brother. At the time

of our interview, they were fighting over a loan he took out that she cosigned for, and now they were calling her to collect the money. In 2015, her father died at the age of 50. She described his death as the most difficult thing that happened to her. After his death, Afra began having problems with loneliness, sadness, sleeping problems, panic attacks, excessive crying, tremors, fearfulness and anxiety. And she said she lacked self-confidence given her upbringing.

Afra first talked with her mother-in-law and neighbors about some of her issues and they suggested a paricari. The first two paricaris she visited were women, and the third was a man. According to her descriptions, like Dr. Sivalingam discussed in Chapter 2, they performed practices in effort to manage the supernatural evil forces affecting her through speaking mantras, cutting lemons in water, and blessing water for her to drink and bathe with. Ultimately, she felt their treatments were ineffective. In regard to the major differences between the three, Afra said the first paricari assigned her fearfulness as the cause of her mental and emotional problems. The second paricari explained that someone did something evil to her. She asked her to bring soil from her father's grave site. The third paricari said her mind was affected by the loss of her father and preformed healing activities that utilizing the power of jinns. These treatments did not work for her. Afra then went to a private hospital and met Dr. Rita. She began attending monthly clinics with Dr. Rita and expressed multiple times during our interview that she felt fortunate to have a good husband with a kind family.

Salma is a Muslim woman in her fifties. At the time of our interview, she lived at home with husband. She has an older son and two daughters who have their own homes. She studied up to O-level and recently retired as a postmistress, and her husband studied up to A-level and works as a postmaster. Salma discussed her struggles with worry and excessive fears, thoughtfulness, lack of sleep and appetite, low energy, and stress. For example, she has trouble sleeping under fans for fear it will fall on her. In 1986, she began to excessively worry about harm—such as an auto accident—befalling her children.

Salma shared she missed her husband and family while she was working as a house maid in the Middle East. Her husband also worked away from him, in another district, for a period of time and she was unable to see him regularly. She had fears about the LTTE and working at the post office during the war. Her continued problems with anxiety led her to go to a Hindu priest (*pucari*) in 2011. She spent around 12,000 LKR on the pucari who performed pujas and mantras and blessed water, however, she found his treatments ineffective. For three years, she did not seek treatment anywhere else. A neighbor lady with similar experiences of excessive worry referred her to the mental health unit at Hospital B (Dr. Pradeep was not there at that time). She later switched to Hospital C after it officially opened in 2016. Salma continued to have worries—similar to Aangela, as part of her matrilineal duties, Salma's major worry at the time of interview was securing enough money to build a house for her daughter.

Hussanniya is also a Muslim woman in her fifties. In the early 1990s, during the Gulf War, she worked as a maid in the Middle East. In 2015, her son had a "love affair" and got married. She expressed irritation by the fact that he married according to his own wishes instead of through a match she approved. Sometime after, he went to the Middle East to work. While her son worked abroad, she lived at home with her daughter-in-law. Thereafter, she developed a lack of appetite, thoughtfulness, excessive crying, and other bodily pains while living with her son's wife, who she described as uncooperative. Her younger sister suggested she visit a local paricari. The paricari told her that someone had charmed or used black magic on her. When her problems did not subside, her sister took her to a private hospital. There, they met Dr. Pradeep who gave her medications. She felt better after taking the drugs but does not use them continuously because of side effect like sweating and tremors. She expressed optimism at feeling better and said things had improved very much upon her son's return from the Middle East. Now, she is worried about trying to find a good husband for her teenage daughter. She also wished for better self-employment skills so she would not have to rely solely on her husband's income.

In these health-seeking narratives, patients' situations were profoundly improved when a partner or family member returned from the Middle East to stay in Sri Lanka. Building previous ethnographic studies regarding the effects of transnational labor on households in Sri Lanka, this research illuminates how gender roles and social relations are destabilized and strained due to a close family member's absence for extended periods of time (Gamburd 2000, 2008; Lynch 2007; Nichter 2002). Such socioeconomic and emotional stressors contributed to idioms of distress and influenced each client's health-seeking strategies.

Sexual Anxieties

I first met Kumar at Hospital B based on Dr. Pradeep's recommendation. He appeared excited when he sat down for our interview. A young Hindu man in his twenties, he mentioned growing up people made fun of his short and thin stature, noting these interactions made him shy and ashamed. He grew up in a large family with five older sisters, one older brother, and one younger brother. Despite having a very difficult life in poverty, he completed his advanced level (A-level) in school. Kumar lived in a three-room house with thatched coconut leaves for a roof. He described his village growing up as a "dangerous place" where LTTE rule led to consist fears of being conscripted, kidnapped, or killed. At the age of seven, he lost his younger brother when his aunt's house was shelled during the war.

A couple of years later, at the age of 44, his father committed suicide by ingesting poison. His father previously worked at a rice mill and had problems with alcoholism. He would often beat his mother. Naturally, the loss of his father's income put the family in an even more desperate position financially, and put tremendous stress and anguish on his mother. She suffered from depression and was utilizing mental health services prior to her son. Kumar had a lot of fears and insecurities growing up and lacked basic items like food and clothes. Despite these numerous stressors, he said he found joy in studying Tamil and excelled in school.

Kumar lived and studied for four years at a Christians children's home. He noted his problems started when he received poor marks on his A-level exams (he expected good results).

He began having sleeping disturbance, less of an appetite, low energy, and sadness. He spent most of his time inside watching TV and sleeping, only going out for work. Crucially, during our multiple interviews with Kumar, he repeatedly brought up his sexual encounters with a fellow male classmate in school. He shared a reoccurring dreams where his family members learn about him having sex with a boy and they all scold him. When asked him what memories bring him lots of stress, he said, "I am thinking about the sexual things I did at the children's home…I am having a big fear that people will talk about the homosexual activities. I fear they will come to my home and humiliate my sisters and brothers."

Kumar expressed discontent over not having a job that suited his education level. He wants to find a government job, a common career goal among young Sri Lankans in order to ensure a decent pay and pension. He initially worked as mason assistant mixing concrete, moving tiles, and making bricks. His older brother had managed the job site before he went to the Middle East for work. With another person managing the job site, he came into conflict with other workers. He described an incident when workers suggested he was crazy, "While I was working as a mason, I took one of the parked vehicles. So they scolded and beat me. They are saying I am a mental patient to drive the vehicle like that." After his troubles on jobsites, his mason boss urged him to pursue another career or continue his education. He later took job at a hotel.

At the insistence of his mother and sister, Kumar went to pucari at an Amman kovil. There he met a pucari who prayed into water, put ash in it, and asked him to drink and bathe in it. He also gave him a charmed item and told him to stay in the house and not go out for three days. He visited this pucari three times. The pucari suggested that Kumar received his mental illness from his mother. Then some other family members took him to a different pucari who wrote something on a betel nut and had him chew it. He also tied a charmed item around his waist. The second pucari said evil spirits had done harmful things to his body and should be removed. Kumar practiced Hinduism, but did not believe these therapies would be helpful. Instead he visited pucaris to please his family members. As he describes, "I don't believe it. But my

community, mother, and the other family members strongly believe. That's why they force me. For the sake of them, I did these things." In addition, Kumar said he attended Sunday masses and received blessings from priests who told him to study the bible.

Kumar's mother accessed monthly clinics at Hospital B to treat depression prior to Kumar meeting Dr. Pradeep. He did not remember a lot about his initial days staying at the ward at Hospital B but, when he first arrived, he received an injection. He stayed a total of 20 days and had a fairly good experience. He watered plants and did other gardening work, played chess with Dr. Pradeep, and watched films. All these activities helped divert his attention away from his problems at that time. He also felt quite comfortable with Dr. Pradeep, enough so that he told him about his sexual experiences and drinking alcohol.

Farook, an unmarried Muslim man, was in his twenties at the time of our interview. He lived at home with his father, mother, two younger sisters, and brother. He had recently finished his A-level exams for civil engineering. While completing his A-level exams in 2016, he had multiple sexual experiences with male classmates. After, he learned from one of these classmates slept with a prostitute multiple times. Upon hearing this, Farook developed repeated thoughts he had contracted the HIV virus, leading to feelings of despair, and suicidal thoughts. His idioms of distress were also attributed to him failing his A-level exams at that time. Moreover, given the stigma surrounding homosexuality in the east and Sri Lanka more generally, he became filled with despair and felt not worthy of living. In addition to thoughtfulness and worry, he also developed problems related to a lack of appetite and energy. After talking to his father about his sexual experience with male classmates, they first went to a paricari who provided mantras and blessed water. However, Farrok did not get relief from his encounter with the paricari. He and his father then went to a private hospital and met Dr. Pradeep. Farook's father worked with Hospital B, so he was familiar with Dr. Pradeep. Dr. Pradeep prescribed two types of drugs (sleeping aid and anti-anxiety) and attends monthly clinics. At some point, Farook's father asked him to stop taking the drugs and Farook told us Dr. Pradeep scolded his father after it led to problems.

John is a Roman Catholic man in his thirties, who lives at home with his mother and father. He has a BS in engineering, and his father has BSC in the physical sciences. His mother studied up to A-level. Since childhood, he had a fear of his family blood and acquiring his family's history of mental illness. Specifically, his family has dealt with excessive fears and worries. In 2016, John developed problems related to breathing palpitation (feeling his heartbeat), numbness, a lack of sleep, and hearing voices in his head. Much of his worrying stemmed from sleeping with a prostitute while he was studying at a university in Colombo. After, he had guilty feelings and fears of having contracted HIV.

To help manage these issues, a priest initially went around his family's house with a cross and blessed each corner to rid it of evil spirits. He also had an experience with a priest where he vomited up a three-colored yarn, felt it in his stomach. After these rituals from priests, John developed more fear and worry. Though he felt better after praying, he believed that he committed a sin in sleeping with a prostitute. He then sought help at Hospital A. He had tests done, but they did not find anything physically wrong with him. Because he was hearing voices, and nothing showed up on his tests at the hospital, he initially thought he was having a "spiritual problem." His mother suggested he go to a pucari, but John held strong feelings against participating in Hindu-related practices. After talking with one of his uncles who works as a priest and has knowledge of psychology, he advised him to seek out a psychiatric doctor to get medications to cure it. Thereafter, he went to a private hospital where he met Dr. Pradeep. Dr. Pradeep advised him to free his mind of thought through anti-anxiety and sleep aid medications and exercise. The doctor also offered his phone number to him if he needed to talk (particularly in the beginning when he was somewhat unstable).

Masculinity and Impoverished Households

We met Yasith in the consultation room at Hospital C. He felt most comfortable meeting there instead of his home or another place he might be seen. Yasith is a Muslim man in his twenties, only his wife knows about him seeking out treatment at mental health units. He shared,

"I don't tell my family members about the illness because they will be highly worried or sad about it. So that's why I hide these things from them….My family is only knowing about my headaches." He was also afraid people would see him at Hospital C. He had a love marriage and lives with his wife and two young sons. Yasith and his wife were educated to O-level and he was employed at the time of the interview. He sometimes worked as a salesman at a cosmetic shop and earns about 32,000 LKR per month. Prior to his marriage five years ago, he developed problems related to stress, sleeping problems, negative thoughtfulness, worry, and headaches. As he described, "While I was playing on the cricket team, at my turn to bat, I was overcome with a lot of anxiety. How can hit the ball? Like that." He searched online through his cellphone and found that it was due to an imbalance of neurons. Thus, he thought it was either a brain or demon problem.

Yasith grew up in a poor village near the beach and semi-urban area. His father severely injured his knee and was able to carry out regular work, leading his family into poverty. Recalling his childhood, Yasith mostly spoke of issues related to his family's financial struggles. He frequently observed his parents fighting, mostly rooted in discussions related to the family's income, and his father sometimes beat his mother. Given these issues, during our interview, he mentioned that did not feel any love and affection from his parents. Once his father stopped working, his mother took out loans to keep the family afloat. His father also borrowed money, without telling his mother, and people in the community complained about his delinquent payments. He felt this gave him a poor reputation at school. He also remembered the 2004 tsunami that washed their house and all their belongings away. These experiences brought total despair and he felt, "all life is like this."

Yasith said his father had conflicts with relatives over matrilineal land inheritance, and the disagreement impacted his relationships with extended family members. He believed his mother should have received land from her mother (a big plot split between her brothers and sister), but it was never allocated, nor was a house built for her. His grandma gave one piece of

land when she was supposed to allocate two. This put his mother in conflict with her siblings. In Grades 4 and 5, after returning from school, there would be little to no food to eat, leaving Yasith hungry. His family's situation diverted his attentions away from his studies, and he stopped going to school. A teacher noted his absence from school, and came by his house to push him to keep attending school. Through the mentorship of this teacher, he earned high marks in his courses. However, Yasith stopped schooling at his O-level, having earned marks too low to progress on his A-level exams.

At that time, Yasith could not stop thinking of his first love. Unrequited, his constant thoughts about her brought headaches and he had desires to commit suicide. After his O-level education, Yasith moved to Pottuvil and worked in a shop with his brother and felt somewhat successful after two or three years. He had a love affair with a Tamil girl from Jaffna from the ages of 18 and 20. They talked over the phone and he fell in love with her. He went to stay with her for two days. However, they had problems after that and ended it. A few weeks later, she went to the doctor to have a cyst inspected on her uterus, and they found out she was pregnant. She took a pill to abort the baby, but it was unsuccessful. She fought with her parents and they found out about Yasith. After that, they took her to his house and discussed marriage. After six months, they did an ultrasound and found that there were no abnormal issues with the baby, While at Yasith's family home, his future wife and mother came into frequent conflict with one another.

Yasith initially tried reading books and yoga exercises in effort control his mental and emotional distress. He was hesitant to use medications because of what he read about side effects online. Around 2008, he decided to go to a private hospital, where he met with Dr. Chamil. Dr. Chamil prescribed him olanzapine and had him attend monthly clinics at Hospital A. Ultimately, Yasith did not feel cured of his problems and stopped the drug because of its side effects (he mentioned reduced speech, etc.). In 2017, he later switched to Hospital C, closer to his house. Dr. Rita prescribed him olanzapine at a lower dosage for two weeks and he had less side effects, such

as decreased appetite, dry mouth, dizziness, lack of sleep, constipation, and his thoughts being are blocked.

Yasith said he still lacks interest in doing work, even when taking medicine. Noting his and family duties, he shard how he hides his illness from worrying about his ability to help provide financially to buy a home for his younger sister's dowry. He married without dowry, and put financial strain at the beginning of their marriage. As he stated, "I want to build a house for my wife. I got the marriage without getting any dowry or house, so I want to build my own house. Right now, I am renting a house." At the time of the interview, he felt depressed because he was not living in a house he owned and had not risen to a higher position in society. His future plans were to go abroad, work, and then build a house.

Ruban is a Tamil Hindu man in his forties who lived at home with his wife and two children. Since 1992, he battled fearfulness (*paayam*) and worry (*kaavalai*). His father was alcoholic and would sometimes clash with his children. He died of throat cancer when Ruban was only 12 years old and it put their family under greater financial constraints. His mother earned money by selling rice and other goods and extended family sometimes helped out with loans. Much of Ruban's fear was derived from the militarized conditions and intensifying war-related violence in Batticaloa District. During the war, government forces would beat, abduct, or kill young men. He remembered his work supervisor was shot and killed, and people lived in constant fear of bomb blasts going off at any moment.

After Ruban married and had children, he developed increased thoughtfulness (*yocinai*). He suggested such overthinking contributed to high blood pressure and the development of a stomach ulcer. From 1992 to 2017, he managed his fear and worry issues though going to priests (pucaris) and temples (kovil), and he worked as the secretary on the board of a kovil. Through going to temple, he felt relaxed and was able to manage his distress without biomedical/allopathic interventions. He had also seen an astrologist but did not find it eased his worry. Moreover, he mentioned, "If people hear about me going to the mental health clinic, they will call me "loose,"

but importantly, it may affect my children and wife." He said his wife had suffered a lot in managing their numerous household responsibilities.

In 2016, he received more pressure and responsibility at work. He managed a grant worth a lot of money, placing a greater workload on him, especially given a lack of staff at his government-based workplace. His friend, who worked as a psychiatric social worker, suggested he visit the hospital for a check-up. He talked to a general practitioner about his problems and overall unstable mind. This doctor referred him to Dr. Viji in the beginning of 2017. Dr. Viji told him it was not a problem, only a "small matter." She put him on an anti-anxiety medication and sleeping aid. She stopped the sleeping aid after one month (which is routine) and followed up with him after a week, and later a month, to see how he was adjusting to the medication. The drugs provided him with reduced overthinking and regular sleep. In general, he felt his fear and worry issues have prevented him from career advancement and becoming an accountant. He missed passing the exam by five marks. Since he began taking medications, he attends work on time and does not feel like he has an illness.

Kanaharatnam, a single Hindu man in his thirties, lived with his sister and her family. He earned a BA in political science and worked as a teacher in a secondary school. Since college, he had a great fear of locked rooms, which would send him into a panic attack. Once, in his college dorm, his friends played a joke on him and locked him in a room. During this experience, he shouted, screamed, and was overcome with panic. After the incident, people gossiped and laughed about it. He became more aware of his problems after talking with a girlfriend in college who had similar problems.

Kanaharatnam felt problems while riding on airconditioned buses, where the doors remained shut for most of the journey. He cannot stay in closed or locked rooms, and the same also applies for airplanes. He felt his phobia caused him to miss chances to travel to Bangladesh, India, and the Maldives. He also gets confused and starts overthinking, which might cumulate into suicidal thoughts. When asked about the causes of his problems, he shared he gave funds to a

kovil in his home village and felt that might have invited envy and evil forces brought by locals and gods. He does not go the paricari because he has allergic reactions to smells and medicines, but he does recite mantras (sometimes accessing them through Facebook) and regularly attends temple every Friday.

In 2016, Kanaharatnam met with Dr. Chamil at a private hospital for five minutes. The doctor told him to lose the fearfulness and learn to stay in locked rooms. Kanaharatnam was not satisfied with Dr. Chamil's consultation—he did not like that he was seeing many patients at a time, and Kanaharatnam did not have time to ask the doctor questions. In light of his continued issues and phobias, his sister suggested he go to another private hospital to see Dr. Pradeep. When we talked during our interview, he had seen Dr. Pradeep two weeks prior and was getting ready for a follow-up. Dr. Pradeep prescribed him sleeping pills and anti-anxiety medications. Kanaharatnam's main therapeutic goal was to stay in a locked room, go on a flight, or ride in an airconditioned bus. He noted if he did not have these problems he would be in a higher position. Feeling pressure from his family members, he considers finding a wife as his main priority.

Conclusion

Within these health-seeking narratives are personalized strategies by which people manage their mental and emotional distress. I argued that there are "family resemblances" between these health-seeking narratives and clients' socioeconomic struggles and stressors given their gender, class, age, ethnicity, and religion. First, I focused on women-headed household clients. Padmadevi's health-seeking narrative highlighted the challenges of losing a husband due to civil war violence, as well as everyday struggles to support and feed her children. Second, I analyzed health-seeking narratives of women patients who live in households with family members participating in transnational labor networks. With transnational labor, husbands, sons, and daughters may be gone for extended periods of time, introducing various stressors into maintaining cohesive households.

Third, I discussed health-seeking narratives and idioms of distress tied to questioning sexual morality. Given his difficult and impoverished life, and the highly stigmatized nature of homosexuality in the region, Kumar experienced a range of socioeconomic stressors and struggles in addition to processing past sexual experiences with fellow male classmates when he was in school. Kumar, John, and Farook sought out different healthcare providers to ease their sexual anxieties. Finally, I document health-seeking strategies for managing distress among male patients who grew up in impoverished situations. Yasith strategically accessed mental health services without telling his family and close friends due to fear of stigma, and to protect his family from worry. The work of culture and meaning-making acts by patients that shapes distress and troublesome affects are evidenced within each of these health-seeking narratives. Though mental health services provide free medication and allow some patients to manage symptoms and forms of somatization, these patients would benefit greatly with developments of outpatient services in order to ensure more time with doctors to hopefully build more effective and meaningful therapeutic relationships.

Chapter 7: Conclusion

After working for more than four decades as a psychiatrist and anthropologist, Arthur Kleinman (2012) wrote a chapter about what major issues and questions, he felt, medical anthropologists will be confronting the next 50 years regarding mental health. For his first question, one highly related to this project, he asked, "What is the difference between social suffering and mental health problems? And how does that difference make a difference?" (Kleinman 2012, 181). As he noted, though the scope of the term "mental health" is wide-ranging and diverse (it encompasses substance abuse, psychosis, anxiety disorders, etc.), there have been efforts by the medical sciences and psychiatry to categorize these mental health problems, thereby creating hundreds of subcategories (Kleinman 1977). Such efforts can trivialize medical conditions while at the same time medicalize social problems. Kleinman (2012) suggests this medicalization represents efforts to develop distinctions between normal and pathological. There is plenty of evidence to suggest that social suffering and diseases overlap (e.g., economic depression and psychological depression are interrelated), diseases and social issues cluster together. Ethnographic evidence shows how everyday forms of suffering become normative and conceptualizes processes of meaning-making acts from societal forces and individual and collective pain. Kleinman points to the importance of ethnographies to explore forms of social death, as well as to understand the problems with psychopharmaceuticals—i.e., too many prescribed, not enough available. He suggests in order to understand health and mental health (in China, Sri Lanka, and elsewhere), research needs to come to terms with sociocultural transformations of distress in ordinary life.

In this dissertation, the concept of death and rebirth is used as metaphor to convey social layers of cultural and symbolic transformations going on in Batticaloa District, local mental health services, doctor-patient interactions, and patients' lives. Many patients, for example, symbolically rebirth at a lower social status (through events, expressions of suffering, or accessing mental health services) and learn to live with this status and identity. In other words,

life transitions happening inside and outside mental health units: war to post-war, resident to "mental" patient, collective suffering to individual suffering, wife to widow, community to clinic and ward activities, abundance of resources to little resources, and similar. People seeking out mental health services usually met a local sociomoral boundary regarding what is (or is not) mad behavior (*paittiyam*) or mental illness (*mana nooy*). Based on ethnographic evidence, this boundary is related to clients' identity (gender, age, socioeconomic status) and what treatments they and their families sought out. In this dissertation, I suggested that with lessening human and material resources, doctors and patients developed personalized strategies to navigate different post-war social transitions and disruptions.

After the departure of Dr. Ramesh from Batticaloa and changes to resources, mental health services have leaned on bureaucratic and medicalized routines. My ethnographic research illustrated how these healthcare routines and procedures have lessened opportunities to build therapeutic relationships with clients by having meaningful discussions, providing counseling and/or psychotherapy, and other therapies that extend beyond medications. With a focus on medicalized knowledge and treatments, personalized meaning-making and creative acts for both doctors/staff and patients/family members in doctor-patient consultations and in community-based programming have become stymied. In turn, there has been an overall lack of development of outpatient services.

Given their backgrounds and identities, patients—along with family members in most cases—developed personalized strategies to cope with distress though sociocultural transformations of themselves and their suffering in health-seeking processes. I argue it is crucial to create meaning-making opportunities in mental health services, particularly in outpatient services, to help manage socioeconomic determinants of clients' mental and emotional distress—i.e., healing beyond medications and (re)focus mental healthcare towards treating the whole person and not just symptoms and diseases. As shown in Chapter 2, such holistic approaches to mental healthcare are historically rooted in South Asian medical and healing traditions. I suggest

a more holistic approach to outpatient services will provide opportunities for patients to develop relationships with medical officers and other mental health staff, allowing them to better address their social determinants of distress. Developing outpatient services and mental healthcare beyond inpatient services and treating serious or severe mental illnesses, I contend, would allow staff in state-run mental health services to develop stronger therapeutic relationships with patients and address their wide variety of needs and problems that extended outside clinic and ward environments and procedures. Given patients' diversity of problems, socioeconomic stressors, experiences, and idioms of distress, these developments may help destigmatize services and increase access to mental healthcare in Batticaloa District more broadly.

Primary Arguments and Contributions to Anthropological and Global Health Studies

My primary argument regarding mental health services and health-seeking strategies is built on four secondary arguments. First, my dissertation project reveals that accessibility and the quality of services are disrupted by a lack of social connection and bi-way referrals between traditional healers and staff at state-run mental health units. As discussed in Chapter 2, such traditional and religious healers are an important part of local therapies for managing forms of mental and emotional distress. Through analyzing historical developments and social transformations regarding mental healthcare in India and Sri Lanka, I revealed that Tamil-speaking populations often conceptualize mental and emotional health as formulated through metaphysical links to gods, external evil forces, family members and community, and home/land. Clients typically sought out traditional and religious healers as a first resort for mental and emotional distress (15 out of 23). Traditional and religious healers in South Asian contexts play a key role in treating mental and emotional distress by mediating those supernatural links among clients interviewed. I mostly profiled Dr. Sivalingam who manages local forms of distress (anxieties about the future, evil eye) through protecting or expelling external evil forces from the body, as well as having other problems linked to local ideas regarding notions of madness and mental illness (e.g., substance abuse, evil spirits).

Among locals and professionals in Batticaloa District, my research illuminates how treatment of mental and emotional distress was not directly associated with state-run professionalized ayurveda/siddha/unani medicines. I contend that though traditional healers provide an essential role of healing everyday forms of distress in villages and towns in eastern Sri Lanka, they are mostly socially and professionally disconnected from state-run allopathic mental health services. This disconnection is partly driven by the British colonial system of healthcare that frowned upon local healing practices. I also illustrate this disconnection through interviews and observations with medical officers and staff who referenced traditional healing practices that abused clients, caused clients to have emotional instability, and had clients discontinue medications. Thus, the main local forms of healing for mental illness and distress are largely disconnected from one another—What Dr. Sivalingam described as "we speak through patients." For patients like Marliya in Chapter 2, such disconnections were related to belief systems, health-seeking histories, and negotiations with local pluralistic therapies. My analysis of historical and current practices of indigenous and traditional forms of healing builds on anthropological studies of medical pluralism in Sri Lanka and South Asia (Halliburton 2004, 2009; Nordstrom 1988, 1989; Nichter and Nordstrom 1989; Obeyesekere 1998; Russell 2005; Taee 2017; Waxler-Morrison 1984, 1988; Wolffers 1988a, 1988b), as well as adds to global mental health campaigns that recognize the potential role of traditional healers and indigenous medicines in filling human resource gaps in mental healthcare in low-/middle-income countries (Incayawar 2009; Incayawar et al. 2009; McInnis and Merajver 2011; Orr and Bindi 2017; Sood 2016; Tribe 2007).

Second, through an historical analysis of state-based mental health services, I show how westernized colonial psychiatry is rooted in containment (tactics used to manage communicable diseases) and custodial tactics (asylums and institutionalization). These initial mental healthcare services were consistently underfunded, under-resourced, and understaffed. As discussed in Chapter 3, the early efforts of psychiatry in Sri Lanka are built on principles of containment modeled off managing the outbreak of diseases. Such measures to prevent the spread of diseases

were important tools in preventing the death or sickness of workers who maintained the production of coffee/tea and other goods during Dutch and British colonial rule. In early Sri Lankan mental asylums, mostly at the longest running institution, Angoda (established 1926), staff were given limited options to treat mental illness, except for a few therapies and institutionalization. Around the time of Sri Lanka's independence in 1948, psychotropic drugs were invented, and helped lead to some decentralization and deinstitutionalization of mental healthcare in or near Colombo. Voluntary services and admissions were also introduced.

With a rising population each year, and given the problems and poor reputation of state-run mental health services over the years, Angoda provides a "key symbol" for mental illness and mental healthcare in Sri Lanka. That is, there is a mixture of truths and falsities about mental illness and state-run psychiatric programs that do not capture the full range of changes and diverse voices among patients and doctors/staff. The condensation of the complexity of mental illness and its care have thus far damaged efforts to increase accessibility, improve services, and destigmatize mental illness and state-based healthcare services. In the early 2000s, with international attention and an influx of resources following the 2004 tsunami, mental health services were decentralized and human resources were improved through training programs for MOs in mental health/psychiatry, PSWs, and other mental health staff. Interventions were also based in outreach and community-based programming—rather than being purely psychiatric—bringing staff out of hospitals to provide various forms of psychosocial support.

Third, in response to "the Angoda model," Dr. Ramesh focused his efforts to improve access and bring awareness about mental health services—what he called "friendly services." Following his personalized strategy for mental health care practice, he developed services and encouraged staff to approach patients with kindness, to go beyond the historically rooted forms of institutionalization and medical care that foster detrimental narratives and ideas about state-run services. As suggested by Dr. Ramesh and other mental health staff, these state-based services helped reproduce stigmatization and the marginalization of patients living with mental illnesses.

In Chapter 4, I demonstrate how Dr. Ramesh's unique personality and leadership qualities were key in negotiations with various humanitarian and global health actors for the expansion of mental health services in Batticaloa District during his tenure. However, due to an increase in the patient population, leadership changes, and overall social changes from a "complex emergency" situation, it was difficult to maintain friendly services—Dr. Ramesh's local version of a Soteria and recovery-based model of mental healthcare—in the manner he and other medical officers had intended. Given Dr. Chamil's personality and leadership style, and limited staff and resources, he formalized a strategy rooted in scientific objectivity, documentation, and improving bureaucratic systems to ensure the current overstretched services could be maintained and sustained and not worsened. All of these factors contributed to the diminishment of mental health-related activities and programming outside hospital spaces. I argue that Dr. Ramesh's charismatic leadership qualities, vision, and social conditions of emergency allowed him to develop his unique approach to mental health services in Sri Lanka. This research on leadership and the development of mental health services in the east adds to anthropological studies and intermediate analyses of local organizational leaders negotiations with global health actors and campaigns that impact access and the long-term sustainability of state-based healthcare services (Hanna and Kleinman 2013; Yang, Farmer and McGahan 2010).

Fourth, with these changes in leadership and programming, mental health units have placed greater emphasis on bureaucratic and medicalized approaches, such as compliance, in doctor-patient interactions. Under Dr. Ramesh's development of mental health services, access to mental healthcare increased and there was a gradual increase of population over the years as clinics and facilities expanded in the district. However, as funds and resources have been shifted away or moved around over the years since Dr. Ramesh's departure and the end of the war in 2009, it has been difficult for Dr. Chamil, medical officers, and staff to practice psychiatry or mental healthcare beyond the medicalized model, let alone trying to carrying out Dr. Ramesh's friendly services.

All of these factors have contributed to medical officers (and other staff) spending less time with clients, and limit their engagement with community members outside of hospitals in their work activities. It is important to note that the training programs for medical officers instituted in the 2000s are based around community engagement and psychosocial support activities. Based on my ethnographic research, within medicalized and bureaucratic routines of doctor-patient consultations, Dr. Chamil, medical officers, and mental health staff are forced to focus on three features: 1) risk and stability; 2) diagnosis, documentation, and technology; and 3) family management. Patients are evaluated according to risk (to others and self) and stability—i.e., what is the client's state when referred to mental health units. In this dissertation, I suggest for clients to come to mental health units, they are usually viewed as on the margins of acceptable sociocultural behavior among family and community members. Such narratives drive people coming to mental health units for the first time. Staff then focus on managing emotional instability through ward admissions in order to monitor and adjust drugs according to clients' symptoms and side effects. I also examined diagnosis, documentation, technologies, and the process of educating patients and family members about basic psychiatry and maintaining drug compliance. A key part of diagnosis and treatment is documentation, as emphasized by Dr. Chamil. Medical officers did not seem to have challenges diagnosing patients for the most part, particularly those displaying extreme forms of emotional instability.

Clients' family support is evaluated in order to maintain clients' drug compliance. This family management of clients mostly matters for those admitted to the ward, but also applies to all patients for the initial medical encounters, unless the client is seeking care without their family's knowledge. In doctor-patient interactions, there is an educating process and displacement of (professional) authority from the doctor to the family member—what Addlakha (2015) called "the ward-home continuum"—to ensure drug compliance and to manage patients once they relapse and/or come to the clinics as outpatients. Given these medicalized and bureaucratic routines, medical officers and staff have little time and resources to address patients'

social determinants of distress. I argue that these routines create de-skilling among medical officers and other staff, where MOs are not able to effectively use local understanding and personalized strategies to provide psychosocial support for clients. This ethnographic research contributes to anthropological studies and our understanding of doctor-patient interactions and power dynamics, particularly in regard to the practice of professionalized allopathic psychiatry in South Asia (Addlakha 2015; Ecks 2013; Nunley 1996, 1998; Wilce 1995, 1997)

In the era of international and global health, challenges to the scope of psychiatry and medical mental health practices are not new and provide some of the earliest critiques of the medicalization of illness in westernized and non-westernized countries. This study illustrates the plurality that exists globally, regionally, and locally regarding psychiatry and biomedicine. Through investigating accessibility and health-seeking for mental and emotional distress, this study makes contributions most broadly to the anthropology of social suffering amidst global mental health campaigns aimed at narrowing resources gaps in technologies, facilities, funds, and staff in low-/middle-income countries.

Directions for Future Research

Ethnographic research is needed to gather the perspectives of clients managing more serious expressions of mental illnesses and distress in eastern Sri Lanka. Global mental health interventions would benefit from future scholarship that aims to capture patients' health-seeking strategies, idioms of distress, and socioeconomic stressors for those associated with bipolar disorder, major depression, and schizophrenia (Kohrt and Mendenhall 2015). Second, research is needed to better capture clients not seeking out allopathic/biomedical services for treating mental and emotional distress, those who exclusively use professionalized state-based indigenous medicine and/or religious/spiritual healing. I ask: How might professionalized ayurveda/siddha be more involved compared to the nonexistent levels of involvement I present in this dissertation? Ethnographic research would need to interview clients from different healthcare sites. This would bring greater understanding of residents with mental and emotional distress who are using

professionalized indigenous medicine in the east. Third, research is needed for a broader understanding of women's experiences and suffering, particularly related to sexuality, abuse, and other culturally sensitive matters. A female ethnographer would better capture these important details among women health-seekers.

Fourth, this research would be greatly informed by the inclusion and representation of various mental health staff and family member viewpoints. For the sake of space and time, I chose to document the experiences of doctors. Fifth, future research examining the experiences of mental health services in Sri Lanka should aim to capture the decision making processes of clients who stopped using prescribed medications, psychotherapy/counseling, and state-run services all together. Future research on these clients would better shed light on the accessibility and quality of mental health services in the east.

Recommendations and Practical Features of Ethnographic Research

Beyond contributions to global health and anthropology literature, this study aims to have practical values in improving mental health services in Batticaloa District and other South Asian countries. First, as shown in Chapter 2, there is a lack of communication and social interaction between state-run mental health services and traditional healers. In order to improve accessibility and alleviate human resource problems in mental health services, I suggest developing referral networks via traditional healers to improve access for those individuals needing biomedical/allopathic mental healthcare. An increased dialogue would also better connect mental health units to local communities, as well as improve psychosocial support services that are lacking in state-run mental health services by referring the patient to traditional healers. However, the consultant psychiatrist and medical officers would have to trust traditional healers to not disrupt drug compliance, physically whip clients, charge large sums of money, and do other abusive practices. Third, mental health services need to build better incentive-based systems in regard to mental healthcare and psychosocial support activities outside of mental health units. Granting authority to traditional healers through training and collaboration with allopathic doctors

within mental health units would allow for mental health staff to feel comfortable referring patients to trained traditional healers for psychosocial support, and thereby extend care beyond current medicalized treatments characterized by a limited availability of counseling services.

Paricari perform healing services for a living and yet they exist apart from mental health units. The psychiatric social assistant (PSA) system—trained community members who referred and connected (potential) clients to mental health units—is volunteer-based and does not provide PSAs with a regular income. The program lacked incentives to carry out regular mental health support programs and monitoring in communities. Paricari can help fill the gaps regarding PSAs and better foster links between communities and state-run mental healthcare. Trainings and building referral networks of trust between different types of doctors will help address human and material deficiencies prevalent in mental health services. Given the history of mental healthcare and patient population inflation, problems of the past are bound to repeat with a heavy focus on bureaucratic and medicalized procedures.

Leadership and personality play a key role in running, developing, and sustaining mental health services. I discussed how Dr. Ramesh was able to access funds through global networks (conference presentations, NGOs, fund raising, etc.) and set up facilities with handpicked medical officers trained by him. However, it might have been more sustainable to have more bureaucratic, systematic, or instituted procedures to sustain changes to leadership and staff dynamics and to ensure the autonomy of medical officers and other staff while the post-war context of Batticaloa changed more broadly. However, I believe these current challenges to mental health units in the east are part of nation-wide systematic gaps in state-based mental health services.

Regarding nursing and attendance staff, there is too much turnover of staff, so they too are not able to build therapeutic relationships with patients. However, from what I observed and heard, the problem of fluctuating nursing and other key staff is a nation-wide problem. Efforts are needed to create opportunities that ensure doctors spend more time with individual patients who need psychosocial support in the district. To guarantee time available, doctors and staff need to

work together and coordinate effectively between the different services available within the district. In addition, leaders like Dr. Chamil need to create opportunities for medical officers and other mental health staff to creatively address clients' needs within and outside of hospitals. I suggest that by focusing on outpatient service development, patients would have less relapses. A greater focus on psychosocial determinants of distress (e.g., lack of work, family conflicts), would allow doctors to develop therapeutic relationships with patients that supports them in the hospital and community. This approach would provide patients with opportunities to spend more time talking with the doctor. These interactions would enable patients and doctors to build relationships that uses the doctor's skills, authority, and power to influence the healing process in positive ways. Such measures would fit nicely with Dr. Chamil's plans to further decentralize clinics to peripheral hospitals.

Current mental health services have made some gains in expanding and developing outpatient services. For one, Dr. Chamil aims to expand clinics to establish more peripheral hospitals (hospitals of a smaller size in rural communities), where each week, one or two medical officers travel to these hospitals to carry out clinics. This ensures that patients living in rural areas would not have to travel to either hospital A, B, or C. And, according to Dr. Chamil, it would lead to more community engagement in mental healthcare activities in the future. This proposed expansion might also include access points to allow those who do not require psychosocial support or psychotherapy to easily pick up medications. Through developing and organizing outpatient services in an efficient manner in the east, people would get opportunities to receive regular psychotherapy or counseling to address social determinant of distress. By analyzing health-seeking processes, I hope this research contributes to designing better programs and interventions that can benefit people with forms of social suffering discussed in Chapter 6: single women households, transnational labor households, male sexual anxieties, and transgenerational poverty.

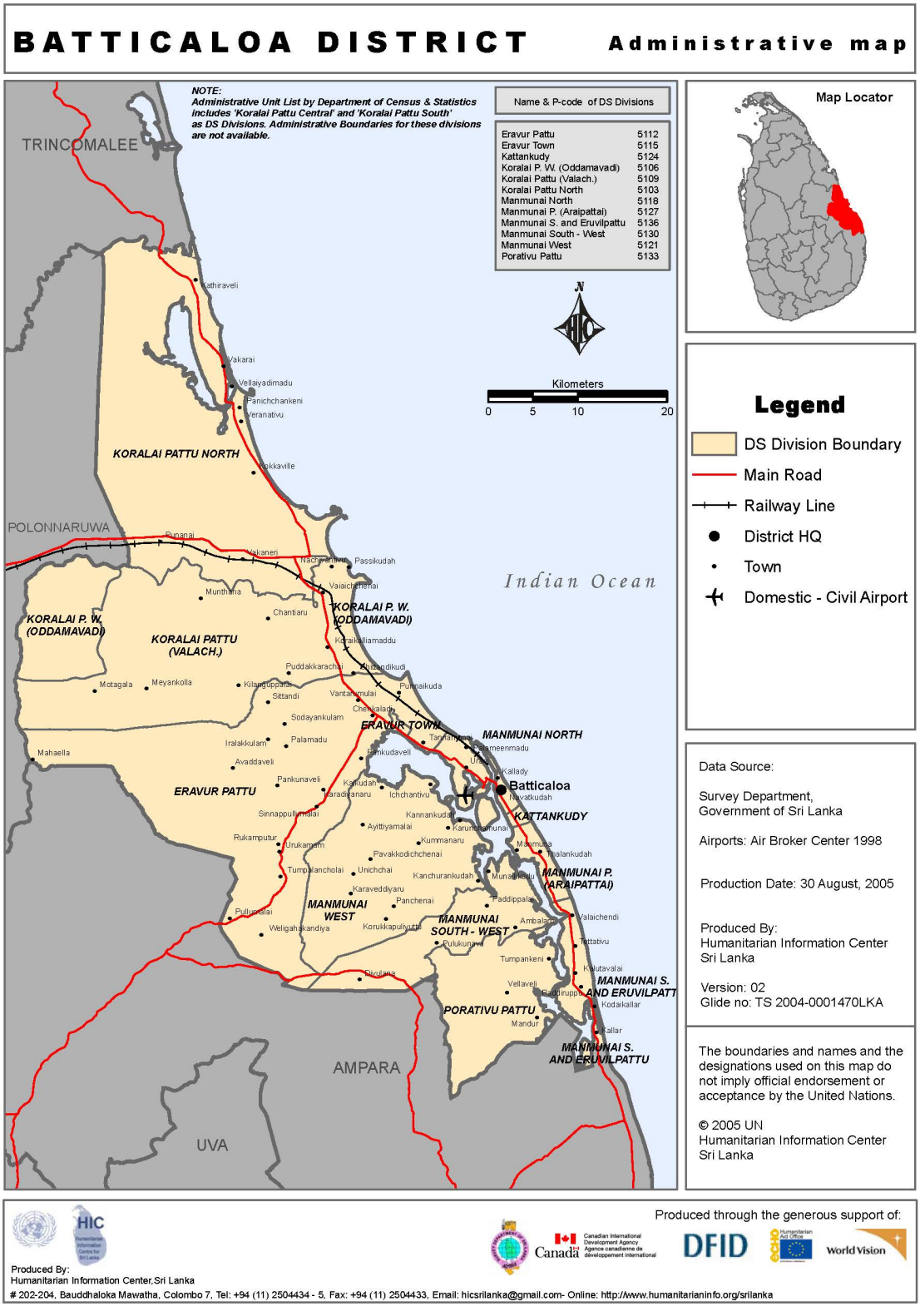
This ethnographic study examines changes to mental health services in Batticaloa District, as well as ways current mental health services influence health-seekers' management and coping strategies for idioms of distress. This research provided an on-the-ground perspective of challenges and opportunities faced by both caregivers and patients in treating and managing localized forms of mental and emotional distress. In Batticaloa District, there exist multiple layers of cultural rationales for seeking out healthcare options given one's idioms of distress, identity, and socioeconomic conditions. Ethnography helps elucidate areas of social stratification and complexity underlying why and how individuals are restricted or enabled to seek healthcare at a given time and place.

APPENDICES

Appendix A: Research Participants and Observation Settings

Data Collection Methods	Characteristics of Participants	Informants
Semistructured Interviews (n=58)	Key Informants	5
	Patients	23
	Family Members	10
	Consultant Psychiatrists	2
	Medical Officer Psychiatrists	6
	Nurses	3
	Ayurveda/Siddha/Unani Doctors	2
	Traditional Doctors/Hindu Priests	2
	Christian Healers	3
	Occupational Therapists	1
	Counselors	1
Life History Interviews	Patients	5
Participant Observation	**Participant Observation Fieldwork Settings**	
	Hospital A	
	Hospital B	
	Hospital C	
	Clinic Doctor-Patient-Family Interactions at Hospital A, B, & C	
	Ward Doctor-Patient-Family Interactions at Hospital A, B, & C	
	Counseling Sessions at Hospital A, B, & C	
	Religious Events/Settings	
	Staff Meetings	
	Christian Healing Events/Settings	
	Paricari and Pucari Events/Settings	
	Home Visits with Psychosocial Workers	
	Patients' and Caregivers' Households (during interviews, meals)	
	Community-Based Mental Health Activities	
	Other Community Events (sporting events, concerts)	

Appendix B: Map of Batticaloa District (UNOCHA 2005)[4]



[4] https://www.ecoi.net/en/document/1011730.html

Appendix C: Healthcare Choices Among Clients

Healthcare Choices Among Clients Interviewed (n=23)							
Choices	**Paricari**	**Pucari**	**Christian**	**State-Run Biomedical**	**Private**	**Self-Care**	**Astrologist**
1st	17.4% (4)	21.7% (5)	17.4% (4)	21.7% (5)	13% (3)	8.7% (2)	0% (0)
2nd	0% (0)	13% (3)	4.3% (1)	21.7% (5)	26.1% (6)	0% (0)	8.7% (2)
3rd	4.3% (1)	4.3% (1)	0% (0)	21.7% (5)	8.7% (2)	0% (0)	0% (0)
4th	0% (0)	0% (0)	0% (0)	4.3% (1)	0% (0)	0% (0)	0% (0)

Appendix D: Therapeutic Systems of Knowledge and Practice

Therapeutic Systems of Knowledge and Practice	Key Characteristics and Findings	Treatment Practices
South Asian and Tamil-Based Medicine and Healing (Chapters 2 and 6)	• Mental and emotional health extends beyond the individual body • Bodies are affected by dynamic metaphysical links between humors, kin, ghosts and gods, and land/soil • Observe the whole person through various techniques (checking pulse, astrology asking questions)	• Traditional healers (*paricaris*) use herbs, oils, and mantras to mediate metaphysical connections to clients' bodies • Oil massages, standing under buckets of water, blessing water
The Angoda Model (Chapter 3)	• Colonial legacy of centralized psychiatric care • Containment tactics (modeled off approaches to communicable diseases) • Custodial tactics (asylums and institutionalization) • State-run mental healthcare is highly stigmatized and contributes to the marginalization of people living with mental illness	• Early occupational therapy • Opium and cannabis • Post-1950s: psychopharmaceuticals • Very limited psychotherapy • Moral therapy
Friendly Services (Chapter 4)	• Dr. Ramesh's alternative mental healthcare to the Angoda model • Like recovery approaches • Less formalized and more friendly • Community-based/outreach • Part of the expansion and decentralization of mental healthcare after the 2004 tsunami humanitarian response	• ECT (Hospital A) • Psychotherapy (the consultant and medical officers trained in cognitive behavioral therapy) • Pharmaceuticals (tablets, injections) • Counseling • Long-term rehabilitation care and housing
Current State-Based Mental Health Services (Chapters 5 and 6)	• More bureaucratic and medicalized routines to handle client loads and limited resources • A focus on risk, stability, and severe mental illness • Emphasize documentation and diagnosis • Family management of drug compliance	• ECT (Hospital A and B) • Psychotherapy (the consultant and medical officers trained in cognitive behavioral therapy) • Pharmaceuticals (e.g., lithium carbonate, olanzapine) • Counseling • Long-term rehabilitation care and housing

Appendix E: Draft Weekly Schedule for Lead Psychiatrist, Hospital B

TIME	SUN	MON	TUE	WED	THU	FRI	SAT
8-12	Counseling		Counseling	Counseling			Counseling
8-1 or 2					Clinic		
8:30	Ward Rounds	Ward Rounds	Ward Rounds	Ward Rounds	Ward Rounds	Ward Rounds	Ward Rounds
8:30-9		ECT		ECT		ECT	
9-12		Clinic					
1-2		Ward Rounds					
2-4		Counseling (if needed)	GBV Case Reviews	\	GBV Case Reviews	Counseling	
3-4			Tea				

Sunday If patients are in the ward, the ward will remain open 7 AM to 7 PM; a nurse will be in the ward. Government workers Care/Counseling: Women in need; Inpatients; Outpatients (discharged from the clinic); Problems: self-harm and suicidal behaviors or thoughts, emotional ventilation.

Monday Clinic: New and Follow-up Patients; Counseling (if needed): Active Listening and Behavioral Therapy (help prioritize patients' problems to solve) and CBT; Meeting with referred patients.

Tuesday Case Review Meetings: Gender-Based Violence (GBV) and Family Members; No occupational therapist.

Wednesday Ward rounds (if patients).

Thursday Clinic for mostly returning patients/inpatients; Gender-based violence and family members.

Friday Counseling: Referrals, Special ward for needed clients.

Saturday Counseling: Mostly for students.

Appendix F: Diagrams of Mental Health Units

Diagram of Hospital B. Consultation Room, One-on-one Consultations

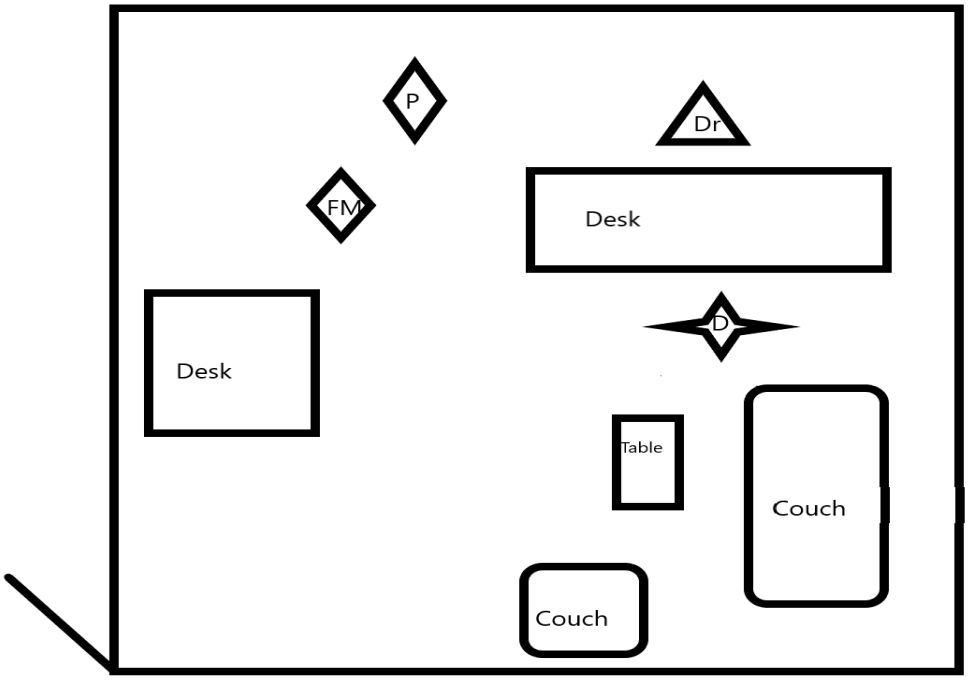
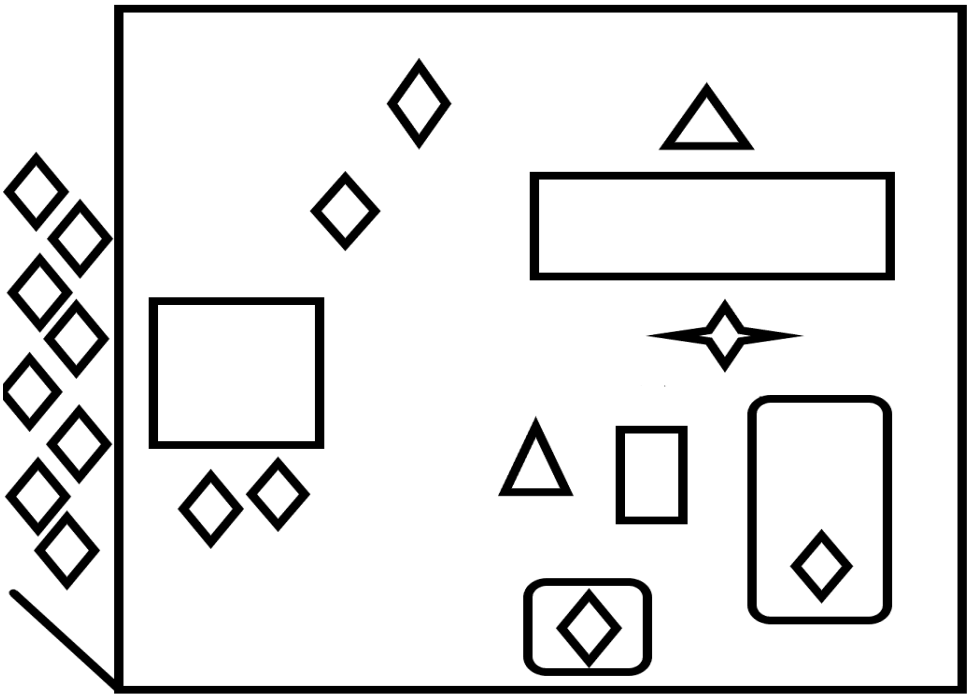


Diagram of Hospital B, Consultation Room, Clinic Day



Key: Patient (P), Doctor (Dr), Family Member (FM), Ethnographer (D).

Diagram of Hospital A, Consultation Room, Clinic Day

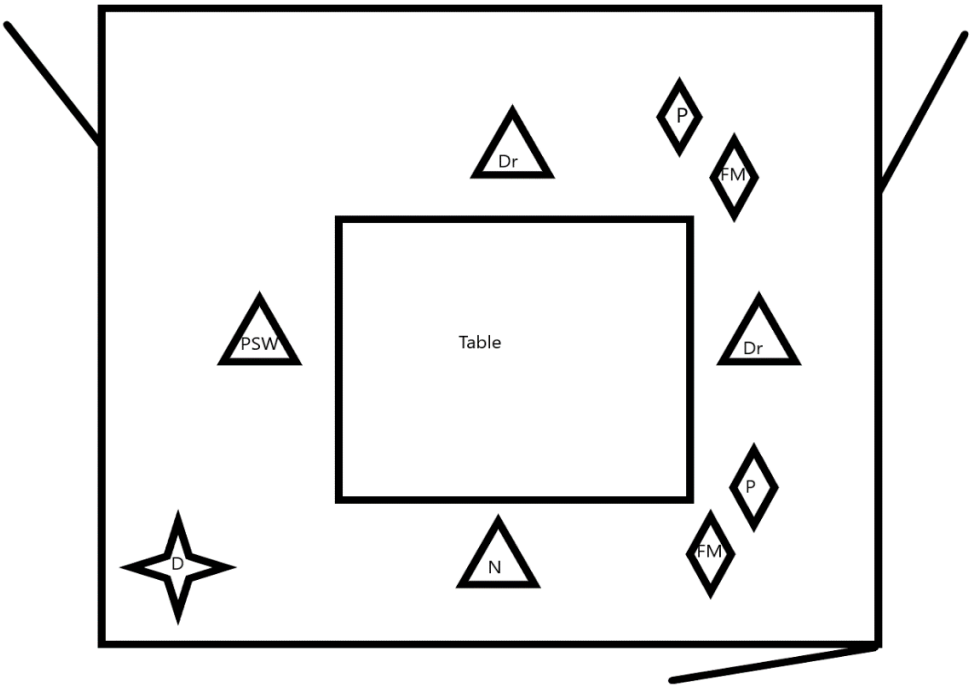
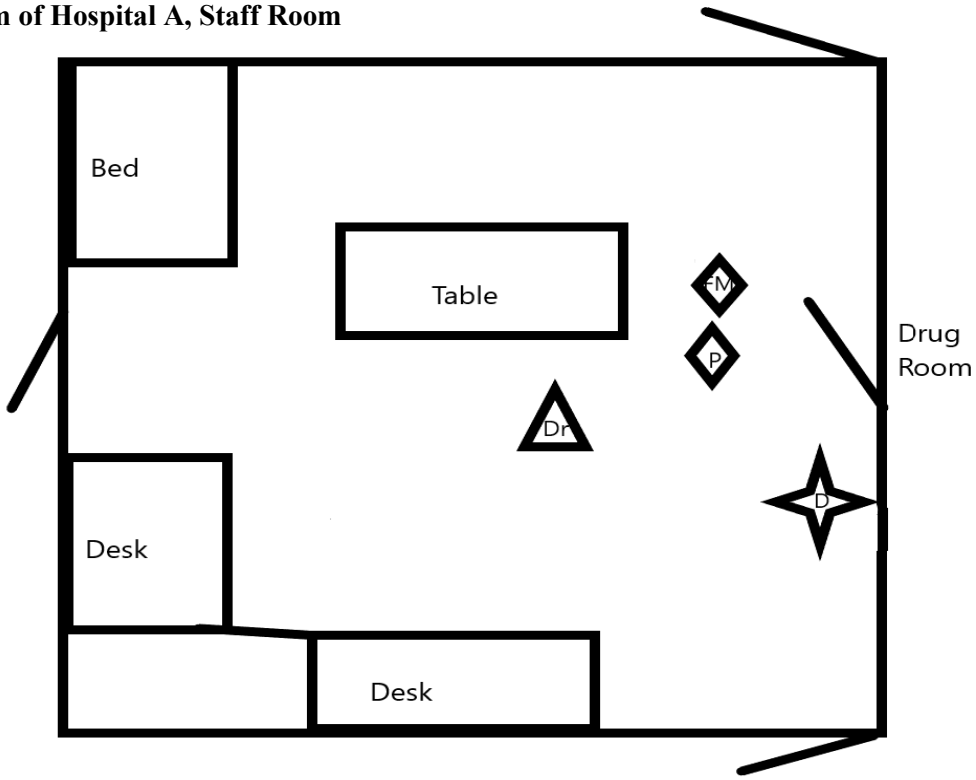


Diagram of Hospital A, Staff Room



Key: Patient (P), Doctor (Dr), Nurse (N), Family Member (FM), Psychiatric Social Worker (PSW), Ethnographer (D).

Diagram of Hospital C, Consultation Room, Clinic Day

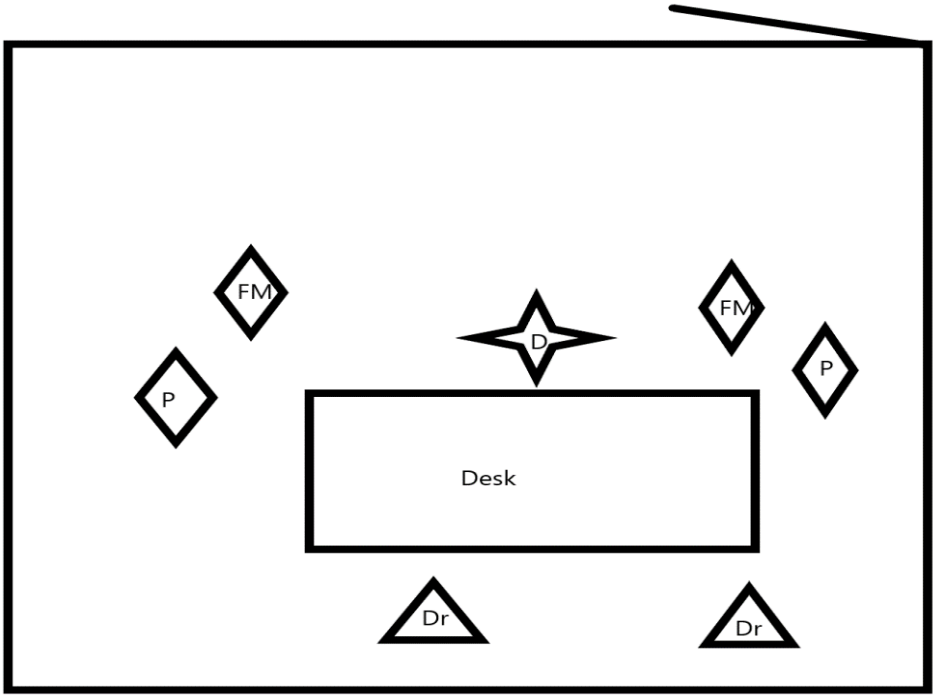
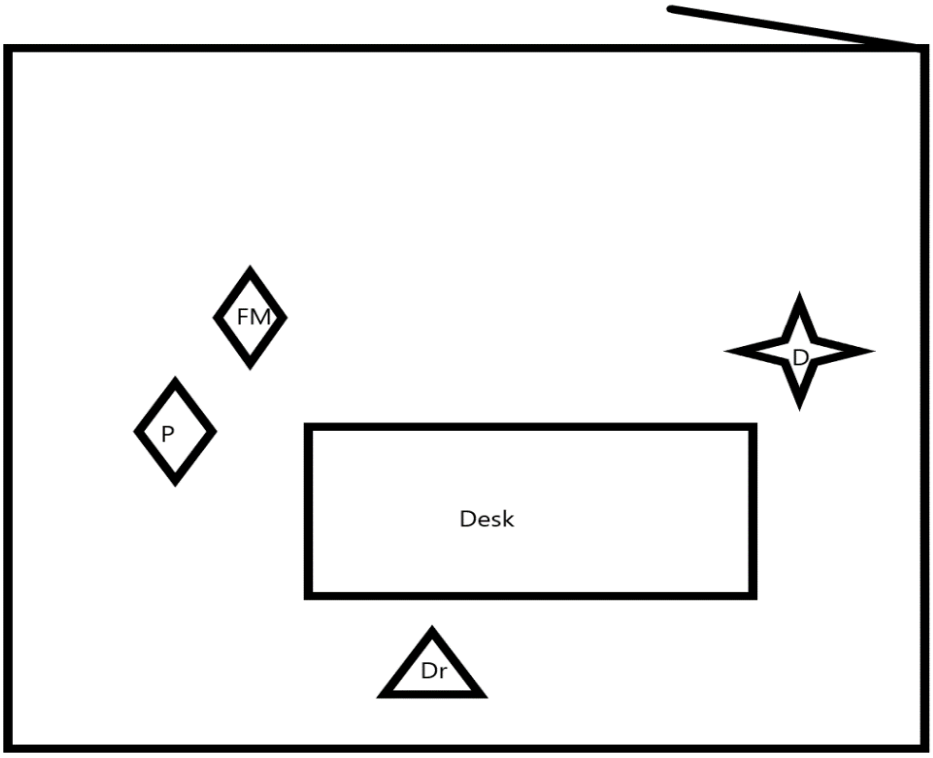


Diagram of Hospital C, One-on-one Consultations



Key: Patient (P), Doctor (Dr), Family Member (FM), Ethnographer (D).

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